Department of Finance and Administration

For the Year Ended
June 30, 2001

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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
State Capitol
Nashville, Tennessee 37243-0260
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John G. Morgan
Comptroller

April 25, 2002

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable C. Warren Neel, Ph.D, Commissioner
Department of Finance and Administration
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the financial and compliance audit of the Department of Finance and Administration for the year ended June 30, 2001.

The review of management's controls and compliance with policies, procedures, laws, and regulations resulted in certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/cj
01/102

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT

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December 4, 2001

The Honorable John G. Morgan
Comptroller of the Treasury
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

We have conducted a financial and compliance audit of selected programs and activities of the Department of Finance and Administration for the year ended June 30, 2001.

We conducted our audit in accordance with government auditing standards generally accepted in the United States of America. These standards require that we obtain an understanding of management controls relevant to the audit and that we design the audit to provide reasonable assurance of the Department of Finance and Administration's compliance with the provisions of policies, procedures, laws, and regulations significant to the audit. Management of the Department of Finance and Administration is responsible for establishing and maintaining internal control and for complying with applicable laws and regulations.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. The department's administration has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

We have reported other less significant matters involving the department's internal control and instances of noncompliance to the Department of Finance and Administration's management in a separate letter.

Sincerely,

Arthur A. Hayes, Jr., CPA,
Director

AAH/cj

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

Financial and Compliance Audit
Department of Finance and Administration
For the Year Ended June 30, 2001

AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 2000, through June 30, 2001. Our audit scope included those areas material to the *Tennessee Comprehensive Annual Financial Report* for the year ended June 30, 2001, and the *Tennessee Single Audit Report* for the same period. These areas included the Medical Assistance Program (Medicaid/TennCare) and the statewide controls administered by the Department of Finance and Administration. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of subrecipient monitoring, budgeting, real property and capital projects management, developmental center operations, and the financial integrity act. The audit was conducted in accordance with government auditing standards generally accepted in the United States of America.

AUDIT FINDINGS

The Tennessee Insurance System (TIS) Is Not Functioning Efficiently and Effectively**

TIS has not been designed, implemented, and maintained in a manner which allows it to function efficiently and effectively. As a result, changes are being made directly to the TIS database (page 7).

Application Development Facility (ADF) Changes Were Not Always Properly Supported or Made Correctly

ADF changes are used to manually adjust participants' accounts on TIS; however, some of these ADF changes had incomplete documentation or were made incorrectly (page 9).

Top Management Must Address TennCare's Administrative and Programmatic Deficiencies**

The audit revealed many serious internal control deficiencies that have caused or exacerbated many of the TennCare program's problems (page 22).

Internal Control Over TennCare Eligibility Is Not Adequate**

For the past seven years, TennCare has failed to implement effective eligibility procedures for uninsured and uninsurable enrollees. TennCare's eligibility redeterminations were not performed adequately, consistently, or timely. TennCare had inadequate eligibility policies and procedures. There were thousands of enrollees

with out-of-state addresses and/or P.O. box addresses enrolled in the TennCare program. TennCare has inadequate staff to verify information on uninsurable applications (page 47).

The TennCare Bureau Continued to Operate Without an Approved Cost Allocation Plan**

The Bureau of TennCare has continued to operate without an approved cost allocation plan, which has prevented the collection of federal matching funds for indirect costs for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (page 82).

TennCare-Related Activities at the Department of Children's Services Were Not Adequately Monitored**

TennCare has not adequately monitored the Department of Children's Services. Although TennCare recognized the need for a strong monitoring effort and has contracted with the Office of Program Accountability Review to provide this service, the monitoring effort still needs improvement (page 69).

Monitoring of the Medicaid Waiver for the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Was Not Adequate**

The TennCare Bureau's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act is inadequate to provide the federally required assurances of health and welfare and of financial accountability (page 70).

TennCare Made Payments on Behalf of Full-Time State Employees, Resulting in Questioned Costs of $476,506 and an Additional Cost to the State of $272,511*

TennCare paid almost $750,000 in capitation payments on behalf of full-time state employees who are classified as uninsured or uninsurable in the TennCare Management Information System. These payments were made because TennCare has not used controls to prevent or recover payments on behalf of state employees (page 55).

TennCare Has Not Ensured an Adequate Process Is in Place for Approval and Review of Services for the Medicaid Home and Community Based Services Waiver**

TennCare has not ensured that the Division of Mental Retardation Services appropriately reviews and authorizes the eligibility of and the allowable services for recipients under the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver and the Elderly and Disabled waivers (page 83).

Internal Control Over Provider Eligibility and Enrollment Was Not Adequate to Ensure Compliance**

TennCare had numerous internal control weaknesses and noncompliance issues related to provider eligibility and enrollment including inadequate provider agreements, not reverifying Managed Care Organization and Behavioral Health Organization providers, and not following departmental rules (page 121).

TennCare Did Not Require the Department of Human Services to Maintain Adequate Documentation of the Information Used to Determine Medicaid Eligibility

TennCare did not require the Department of Human Services to maintain adequate documentation to support medicaid eligibility information including income, resources, and medical expenses (page 36).

TennCare's Monitoring of the Payments for the Pharmacy Program Needs Improvement, and TennCare Needs to Maintain Annual Drug Use Review Reports

TennCare's monitoring of the payments for the pharmacy program needs improvement. In addition, management could not locate the annual drug use review reports that were sent to the federal government (page 88).

TennCare Management Information System Lacks the Necessary Flexibility and Internal Control**

Management of the Bureau of TennCare has not adequately addressed critical information system internal control issues. This has contributed to a number of other findings in this report (page 132).

TennCare Made Payments on Behalf of Incarcerated Adults Resulting in $4,278,607 in Federal Questioned Costs**

TennCare does not have adequate controls in place to prevent capitation payments to managed care organizations and behavioral health organizations when enrollees become incarcerated. In addition, TennCare does not have a process to retroactively recover all capitation payments from the MCOs when enrollees are incarcerated (page 90).

TennCare Reimbursed the Department of Children's Services for Unallowable Costs Resulting in Questioned Costs of $803,576**

TennCare has paid the Department of Children's Services for services that were outside the scope of its agreement with the Bureau of TennCare during the year ended June 30, 2001 (page 59).

TennCare Paid the Department of Children's Services Over $1.1 Million for Services That Are Covered by and Should Be Provided by Behavioral Health Organizations*

TennCare has paid the Department of Children's Services for services that they also paid the behavioral health organizations to provide (page 64).

TennCare Did Not Ensure Adequate Monitoring of the Medicaid Home and Community Based Services**

The TennCare Bureau did not ensure that the Division of Mental Retardation Services complied with its contract monitoring requirements (page 75).

TennCare Did Not Recover Fee-For-Service Claims Paid to Providers and Used Federal Matching Funds for Capitation Payments Paid to Managed Care Organizations for Deceased Individuals Including Those Who Had Been Dead for More Than a Year**

TennCare did not recover fee-for-service claims paid to providers and used federal matching funds for capitation payments paid to managed care organizations for deceased individuals including those who had been dead for more than a year (page 95).

Financial Integrity Act Reports Did Not Include TennCare*

Although Executive Order 23 was issued on October 19, 1999, to transfer the TennCare program and its related functions and administrative support from the Department of Health to the Department of Finance and Administration, the reports filed by the department that were due on December 31, 1999, did not include TennCare's operations, and the Bureau of TennCare still did not report the results of the internal control examination (page 153).

TennCare Did Not Comply With the Special Terms and Conditions of the TennCare Waiver**

Management did not comply with 9 of 25 applicable special terms and conditions (STCs) of the TennCare Waiver, and controls over compliance with the STCs need improvement. Federal financial participation in the program is contingent upon compliance with the STCs (page 115).

TennCare Does Not Have a Court-Approved Plan to Redetermine or Terminate the TennCare Eligibility of SSI Enrollees that Become Ineligible for SSI *

Because TennCare does not have a court-approved plan, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees that become ineligible for SSI. Rather than getting a plan, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and is receiving Medicaid in another state,

or requests in writing to be disenrolled (page 42).

TennCare Should Seek Revisions to the TennCare Waiver Which Would Require Specific Medical Conditions for Eligibility

As a result of the design of the program, the program currently does not have medical criteria to indicate what conditions are considered uninsurable. Furthermore, this decision is made by the insurance companies and not by TennCare staff (page 44).

Activities of the Office of Program Accountability Review (PAR) Were Not Performed in a Timely Manner

Interdepartmental contracts were not finalized before work was performed, reports were not issued in a timely manner, and PAR did not submit an annual report (page 142).

The Department Is Not Following Billing Policies

The Office of Business and Finance did not initiate billings for monitoring services in accordance with Policy 18 (page 144).

* This finding is repeated from the prior audit.
** This finding is repeated from prior audits.

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report which contains all findings, recommendations, and management comments, please contact

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Audit Report
Department of Finance and Administration
For the Year Ended June 30, 2001

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Department of Finance and Administration
For the Year Ended June 30, 2001

INTRODUCTION

POST-AUDIT AUTHORITY

This is the report on the financial and compliance audit of the Department of Finance and Administration. The audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit to "perform currently a post-audit of all accounts and other financial records of the state government, and of any department, institution, office, or agency thereof in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller."

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate.

BACKGROUND

The mission of the Department of Finance and Administration is to provide financial and administrative support services for all facets of state government. The business, finance, and managerial functions of state government are centralized here; the department prepares and executes the state budget, accounts for state revenues and expenditures, operates a central data processing center, plans and reviews construction and alteration of state buildings, and controls state-owned and leased property.

The Department of Finance and Administration contains ten divisions: Budget, Administration, Accounts, Office for Information Resources, Insurance Administration, Resource Development and Support, Real Property and Capital Projects Management, TennCare, Mental Retardation, and Social Services.

Executive Order 9 transferred the management and operations of Arlington Developmental Center and the West Tennessee Office of Community Services to the Department of Finance and Administration, effective February 7, 1996. In addition, Executive Order 10 transferred the management and operation of Arlington, Clover Bottom, Greene Valley, and Nat T. Winston Developmental Centers, and the Middle and East Tennessee Offices of Community Services to the Department of Finance and Administration, effective October 14, 1996. Included in this transfer was the Central Office Programmatic and Administrative Support within the Division of Mental Retardation Services.

Executive Order 21 was issued on July 29, 1999, to clarify the administrative responsibilities of the Department of Finance and Administration. It stated that the Department of Mental Health and Mental Retardation Administrative Services Division will remain part of the Department of Mental Health and Mental Retardation but will perform all administrative support functions and administer the major maintenance and equipment appropriation for the Division of Mental Retardation Services.

Executive Order 23 was issued on October 19, 1999, to transfer the TennCare program and its related functions and administrative support from the Department of Health to the Department of Finance and Administration.

An organization chart of the department is on the following page.

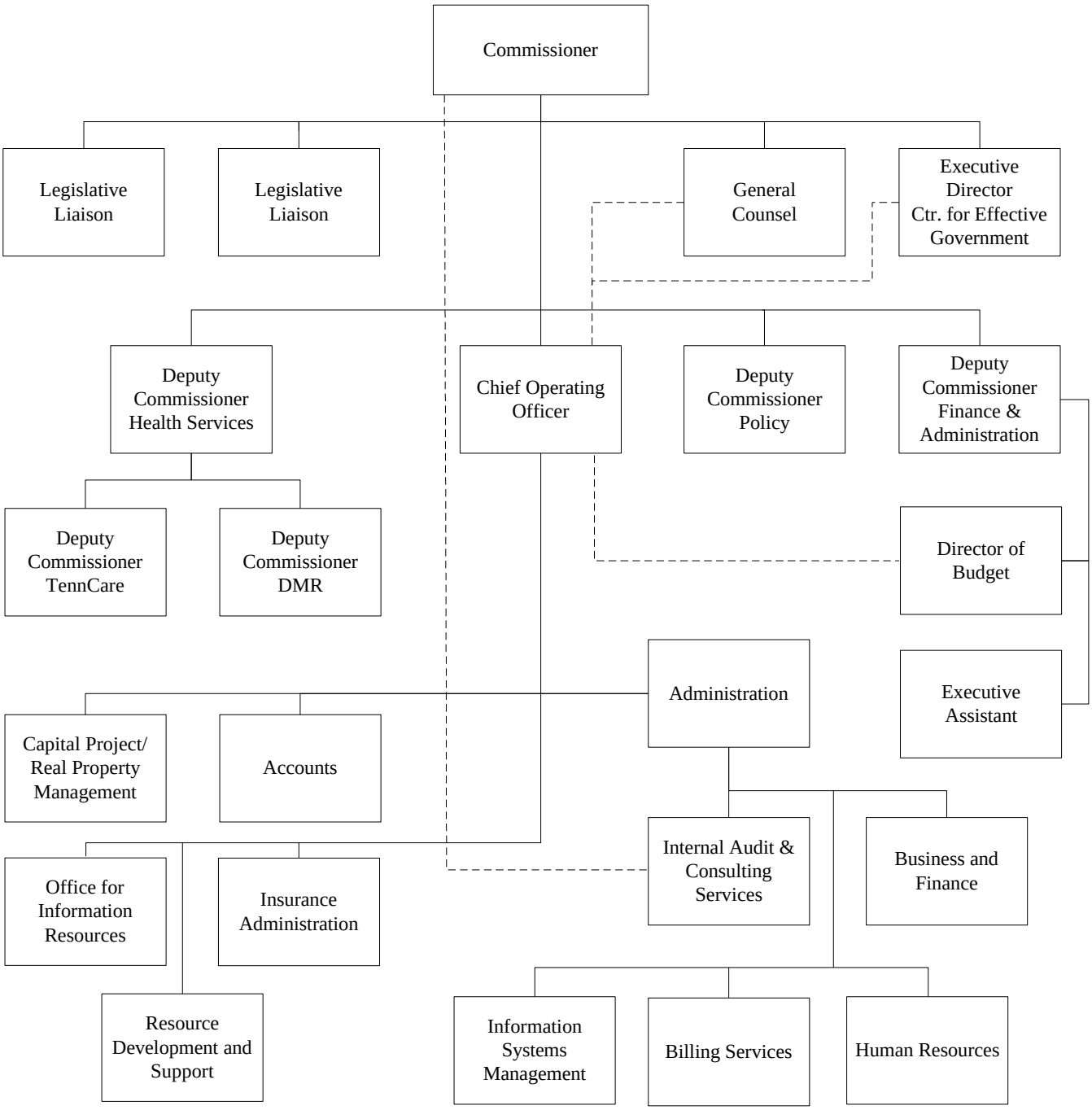
AUDIT SCOPE

We have audited the Department of Finance and Administration for the period July 1, 2000, through June 30, 2001. Our audit scope included those areas material to the *Tennessee Comprehensive Annual Financial Report* for the year ended June 30, 2001, and the *Tennessee Single Audit Report* for the same period. These areas included the Medical Assistance Program (Medicaid/TennCare) and the statewide controls administered by the Department of Finance and Administration. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of subrecipient monitoring, budgeting, real property and capital projects management, developmental center operations, and the financial integrity act. The audit was conducted in accordance with government auditing standards generally accepted in the United States of America.

PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Department of Finance and Administration filed its report with the Department of Audit on August 31, 2001. The follow-up report on findings related to the Medical Assistance Program (Medicaid/TennCare) was received October 25, 2001. The follow-up of these findings, along with a follow-up of all prior Department of Finance and Administration audit findings, was conducted as part of the current audit.

DEPARTMENT OF FINANCE AND ADMINISTRATION



Note: Dashed lines indicate to whom a division reports for business matters if it is different from administrative matters.

RESOLVED AUDIT FINDINGS

The current audit disclosed that the Department of Finance and Administration has corrected the previous audit findings concerning

- the Division of Accounts' post-audit review process,
- labor charges related to monitoring,
- recordkeeping for Clover Bottom Developmental Center equipment,
- Developmental Centers' payroll calculations,
- the written approval and clarification of grant requirements,
- case management services documentation,
- fraud not being reported to the Comptroller of the Treasury,
- TennCare's committing funds without approval,
- policies and procedures for accrued liabilities,
- controls over checks, and
- TennCare's not complying with audit requirements for long-term care facilities.

REPEATED AUDIT FINDINGS

The prior audit report also contained findings concerning

- reconciliation of the Tennessee Insurance System and the State of Tennessee Accounting and Reporting System (STARS),
- TennCare's numerous and serious administrative and programmatic deficiencies,
- the TennCare management information system's lack of flexibility and internal control,
- internal control over TennCare eligibility,
- TennCare's not having a court- approved plan for the redetermination of eligibility for individuals who have lost Supplemental Security Income benefits and TennCare's not having adequate due-process procedures in place for enrollees,
- unallowable payments to the Department of Children's Services,
- payments to the Department of Children's Services that should have been made to Behavioral Health Organizations,
- TennCare's payment rates to the Department of Children's Services,
- monitoring of TennCare-related activities at the Department of Children's Services,

- TennCare's monitoring of the Medicaid Waiver for Home and Community Based Services,
- the Division of Mental Retardation Services' monitoring of the Medicaid Home and Community Based Services Waiver,
- claims not paid in accordance with the Home and Community Based Services Waiver,
- TennCare's cost allocation plan,
- the approval and review process of services for the Medicaid Home and Community Based Services Waiver,
- payments for incarcerated adults,
- recovery procedures for payments on behalf of deceased enrollees,
- unallowable payments for full-time state employees,
- Medicare cross-over claims processing,
- TennCare's not requiring contractors and providers to make disclosures concerning suspension and debarment,
- controls over access to the TennCare Management Information System,
- the administration and monitoring of contracts,
- monitoring of the graduate medical schools,
- controls over TennCare premiums,
- controls over financial change requests,
- TennCare's payment of old claims,
- compliance with TennCare's Special Terms and Conditions,
- internal control over provider eligibility and enrollment,
- unnecessary utilization of care and services and suspected fraud,
- Automated Data Processing risk analysis and system security review,
- revision of departmental rules,
- controls over eligibility of state-only enrollees, and
- not including TennCare in Financial Integrity Act reports.

These findings have not been resolved and are repeated in the applicable sections of this report.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

AREAS RELATED TO TENNESSEE'S COMPREHENSIVE ANNUAL FINANCIAL REPORT AND SINGLE AUDIT REPORT

Our audit of the Department of Finance and Administration is an integral part of our annual audit of the *Comprehensive Annual Financial Report* (*CAFR*). The objective of the audit of the *CAFR* is to render an opinion on the State of Tennessee's general-purpose financial statements. As part of our audit of the *CAFR*, we are required to gain an understanding of the state's internal control and determine whether the state complied with laws and regulations that have a material effect on the state's general-purpose financial statements.

The Department of Finance and Administration is responsible for maintaining the state's central accounting system and preparing the *CAFR*. The department, in conjunction with other state agencies, provides centralized statewide controls in the following areas:

- statewide accounting system,
- budgets and appropriations,
- cash receipts and disbursements,
- payroll transaction processing, and
- fixed asset records.

As part of our audit of the *CAFR*, we reviewed selected controls over these areas in the Department of Finance and Administration and other state agencies.

To address our statewide audit objectives, we interviewed key department employees; reviewed applicable policies and procedures; examined, on a test basis, evidence supporting the amounts and disclosures in the financial statements; performed analytical procedures, as appropriate; assessed the accounting principles used and significant estimates made by management; and evaluated the overall financial statement presentation. Our testing focused on the propriety of financial statement presentation, the adequacy of internal control, and compliance with applicable finance-related laws and regulations.

Our audit of the Department of Finance and Administration is also an integral part of the *Tennessee Single Audit*, which is conducted in accordance with the Single Audit Act of 1984, as amended by the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. The Single Audit Act requires us to determine whether

- the state complied with laws and regulations that may have a material effect on each major federal financial assistance program, and

- the state has effective internal control to provide reasonable assurance that it is managing major federal financial assistance programs in compliance with applicable laws and regulations.

We determined that on June 30, 2001, the Department of Finance and Administration had the Medical Assistance Program (Medicaid/TennCare) which was material to the *CAFR* and to the *Single Audit Report*.

To address the objectives of the *CAFR* and the *Single Audit Report*, as they pertain to the Medical Assistance Program, we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of transactions. For further discussion, see the applicable section (Medicaid/TennCare).

We have audited the general-purpose financial statements of the State of Tennessee for the year ended June 30, 2001, and have issued our report thereon dated December 4, 2001. The opinion on the financial statements is unqualified. The *Tennessee Single Audit Report* for the year ended June 30, 2001, will include our reports on the schedule of expenditures of federal awards and on internal control and compliance with laws and regulations. These reports include reportable conditions and material weaknesses resulting from this audit. These reports also include instances of noncompliance, some of which resulted in a qualified opinion on compliance with requirements of the federal Medicaid/TennCare program.

The audit of the department revealed the following findings in areas related to the *CAFR*.

- The Tennessee Insurance System is not functioning efficiently and effectively.
- Application Development Facility changes were not always properly supported or made correctly.

1. The Tennessee Insurance System is not functioning efficiently and effectively

Finding

As noted in the five prior audits, the Tennessee Insurance System (TIS) has not been designed, implemented, and maintained in a manner which allows it to function efficiently and effectively. As a result, changes are being made directly to the TIS database through the Application Development Facility (ADF), necessitating manual reconciliations and adjustments. Management responded to the prior audit finding by stating that accounting transactions have been brought up-to-date with only an occasional problem, and two accounting positions have been added to the Division of Insurance accounting section. Also, the TIS upgrade project began in March 2000. Management stated that in addition to the TIS upgrade project, the division had implemented the TIS automated reconciliation project. Our review indicated that most accounting transactions were up-to-date, positions were added, and the TIS upgrade project is in progress. We also found that the automated reconciliation process is functioning and items that still require manual reconciliation are being handled appropriately. However, the upgrade project

and Master Transaction Study are not complete. ADF is still used, and large differences between TIS and the State of Tennessee Accounting and Reporting System (STARS) still occur that result in manual processing.

The division is still using ADF, a software program, to manually adjust participants' accounts on TIS. These adjustments to participants' accounts are made directly in the TIS database rather than through transactions. The system's security must be overridden in order for an ADF change to be made. The division sends a request for the ADF change to the department's Information Systems Management (ISM) group, which in turn submits a request to the Office for Information Resources (OIR). OIR assigns one of its employees to make the ADF changes on the TIS database. As noted in the prior audit, overriding system security to make manual adjustments is a significant deficiency in the design and operation of the system.

The Division of Insurance Administration uses ADF as a "quick fix" to correct participant balances or errors attributable to unresolved system problems. Although division staff maintain paper documentation of the ADF changes, the system has no history or record of the changes because division staff simply overwrite previous information in the database. If the system had been designed and was functioning properly, use of ADF would not be necessary. As previously noted, making changes directly to a database instead of correcting errors through properly authorized and documented transactions circumvents system controls.

In addition, when the TIS database is corrected using ADF, STARS is not updated concurrently. As a result, the two systems do not agree. We noted that differences between the daily net change in the TIS database and the cumulative accounting transactions passed from TIS to STARS daily during the year ended June 30, 2001, ranged from ($417,929.19) to $493.50. Differences in the daily net change must be researched and adjusted as necessary. Again, if the system had been designed and was functioning properly, there would not be a need for these additional manual procedures.

Recommendation

To ensure that all TIS system problems are corrected as soon as possible, the Director of Insurance Administration should complete the TIS upgrade project that began in March 2000 and begin the TIS Master Transaction Study that is scheduled for Fiscal Year 2002. As the system problems are corrected, the use of ADF changes should be minimized and, if possible, eventually eliminated. As problems arise in the future, causes of the problems should be quickly identified, and TIS should be corrected quickly through program changes or other appropriate means.

Management's Comment

We concur. The issue of reconciliation between TIS and STARS has been the topic of considerable effort on the part of the Division for quite some time. The Division has implemented a number of changes including the TIS reengineering project implemented in

March of 2000 in order to address the balancing between TIS and STARS. As noted, accounting transactions have been brought up to date, positions have been added and the TIS Automated Reconciliation Project has been completed. All of these improvements have positively impacted the TIS to STARS balancing processes.

The TIS Upgrade Project began in March of 2000 and is scheduled for completion by April 2003. The planning and analysis phases of the project have been completed. The design phase is scheduled for completion by the end of January 2002. The project is intended to enhance the capabilities of the present system as well as improve its maintainability. Key areas that will be addressed with this systems project include the following:

- Enhance existing functionality,
- Add new functions,
- Enable TIS to balance with STARS,
- Improve interfaces with other systems,
- Improve processing, and
- Improve reporting.

Every effort is being made to correct as many problems as possible in the current version of TIS while designing the upgraded TIS so that the use of ADF will be minimized.

The TIS Master Transaction Study is scheduled to begin after July 1, 2003.

In summary the Division of Insurance Administration is committed to upgrade TIS, to the judicious use of ADF changes and subsequently to resolve the issue of TIS to STARS balancing.

2. Application Development Facility changes were not always properly supported or made correctly

Finding

Application Development Facility (ADF) changes were not always properly supported or made correctly. The Division of Insurance Administration uses the ADF software program to manually adjust participants' accounts on the Tennessee Insurance System (TIS). ADF is a "quick fix" to correct balances or errors attributable to unresolved system problems. When finding 1 is resolved, the use of ADF should no longer be needed. Currently, however, ADF is the only method available to correct errors or adjust participants' accounts that cannot be adjusted directly through TIS.

ADF changes overwrite previous information in the database without leaving a record of the change in the system. For control purposes, the division maintains paper documentation for each ADF change. However, for 5 of 25 items tested (20%), the ADF change either was not

made correctly or could not be verified for correctness. The testwork produced the following results:

- For 3 of the 25 ADF changes tested (12%), the changes were made incorrectly or not made at all.
- For 2 of the 25 ADF changes tested (8%), the changes could not be verified for correctness due to lack of documentation.

If ADF changes are not made correctly, then participants' accounts on the Tennessee Insurance System will be inaccurate. These situations contribute to the TIS reconciliation problems. If paper documentation is not maintained for ADF changes, the related data change will not be supported at all.

Recommendation

The Division of Insurance Administration should continue its efforts to reengineer the TIS system in order to eliminate the need for ADF changes. Until the time when the reengineering is complete, the division should concentrate its efforts to keep ADF changes minimal. When ADF changes are necessary, extra care should be taken to ensure that the changes were made as intended. The Director should ensure that all changes are reviewed by a supervisor to ensure that the change made was the correct one. The Director should also ensure that complete paper documentation is maintained for all ADF changes.

Management's Comment

We concur. The planning and analysis phases of the TIS Upgrade Project have been completed. The general design phase of the project is expected to be completed by the end of January 2002. Detail design will then resume. The project is scheduled for implementation in April 2003. Every effort is being made to correct as many system problems as possible in the current version of TIS while designing the upgraded TIS so that the current use of ADF is minimized.

The Division's Accounting Technician II reviews all ADFs processed to ensure that changes were made as intended. An additional step will be put in place where a supervisor reviews all ADFs after completion. Also, in order to ensure that complete paper documentation is maintained for all ADF changes, a dedicated printer has been installed at the workstation where ADF changes are conducted.

MEDICAL ASSISTANCE PROGRAM (MEDICAID/TENNCARE)

The Medical Assistance Program (Medicaid/TennCare) is the largest federal program in the "Medicaid cluster" of grant programs. The State Medicaid Fraud Control Units and the State

Survey and Certification of Health Care Providers and Suppliers grant programs are also included in the Medicaid cluster. These two programs provide significant controls over the expenditures of Medicaid funds.

Our audit of the TennCare program focused primarily on the following areas:

- General Internal Control;
- Activities Allowed or Unallowed and Allowable Costs / Cost Principles;
- Cash Management;
- Eligibility;
- Matching, Level of Effort, Earmarking;
- Period of Availability of Federal Funds;
- Procurement and Suspension and Debarment;
- Program Income;
- Federal Reporting;
- Subrecipient Monitoring;
- Special Tests and Provisions;
- Schedule of Expenditures of Federal Awards;
- Financial (Accounts Receivable, Accrued Liabilities, Other Liabilities, Deferred Revenue); and
- TennCare Management Information System General Controls.

The primary audit objectives, methodologies, and our conclusions for each area are stated below. For each area, auditors documented, tested, and assessed management's controls to ensure compliance with applicable laws, regulations, grants, contracts, and state accounting and reporting requirements. To determine the existence and effectiveness of management's controls, we made inquiries of management and staff; completed internal control questionnaires; reviewed policies, procedures, and grant requirements; prepared internal control memos; performed walk-throughs; performed tests of controls; and assessed risk.

General Internal Control

Our primary objectives for general controls were to obtain an understanding of, document, and assess management's general controls and to follow up on the prior audit findings concerning controls over financial change requests, management's general controls, controls over checks, inadequate contracts and monitoring of contracts, departmental rules, and fraud not being reported to the Comptroller of the Treasury. We interviewed key program employees; reviewed organization charts, descriptions of duties, and responsibilities for each division, and correspondence from the grantor; and considered the overall control environment of the

TennCare program. We also reviewed the current departmental rules and interviewed key employees to determine the status of the discrepancies noted in the prior audit finding. We obtained an understanding of and documented TennCare's controls over checks and financial change requests. We examined TennCare's contracts and obtained an understanding of TennCare's monitoring over these contracts.

The results of this area are as follows:

- we noted several deficiencies in management's general controls over the TennCare program, as described in finding 3;
- controls over checks were adequate;
- controls over financial change requests need improvement, as described in finding 6;
- TennCare did not ensure that there was adequate system security for the Automated Client Certification Eligibility Network (ACCENT) system as noted in finding 5;
- we noted inadequate contracts and weaknesses in the monitoring of contracts as noted in finding 4;
- we also determined that TennCare still had not adequately complied with its rules that were in effect during the audit period, as discussed in finding 7; and
- we determined that management's controls for reporting fraud were adequate.

Activities Allowed or Unallowed and Allowable Costs / Cost Principles

The primary objectives of this area were to determine if grant funds were expended only for allowable activities and to follow up on prior-year audit findings.

To determine if grant funds were expended for allowable activities only, we selected a nonstatistical sample of payments to the managed care organizations (MCOs) to determine if the correct capitation amount had been paid. An understanding was obtained of the procedures TennCare used to calculate payments to the behavioral health organizations (BHOs). We tested nonstatistical samples of Medicaid claims (e.g., nursing home claims) to determine if the claims were paid correctly and if claims were pursuant to a pre-admission evaluation. CAATs were used to search the payment data files for payments made on behalf of deceased enrollees and adult prisoners.

A nonstatistical sample of reimbursement claims paid to the Department of Children's Services (Children's Services) was tested. Supporting documentation for the claims was examined to determine if the charges were valid and allowable. The related case files at the vendors were reviewed for evidence that the children in the sample had actually received the services for which TennCare had reimbursed Children's Services. CAATs were used to search payment data files that contained payments made by TennCare to Children's Services for payments made on behalf of incarcerated youth, therapeutic payments for individuals 21 and over, unallowable payments for leave days, and services that should be covered by the BHOs.

We also used CAATs to identify payments made to Children's Services on behalf of children under three years of age receiving behavioral health services.

Supporting documentation for all significant expenditure items was obtained and examined. We performed reconciliations to determine if the amounts recorded in the State of Tennessee Accounting and Reporting System (STARS) agreed with the amount of checks issued and reported in federal reports. Significant supplemental funding pool payments were recalculated to test for compliance with the payment methodologies approved by the grantor.

We also obtained an understanding of TennCare's monitoring of payments for the pharmacy program. We interviewed key employees and selected a nonstatistical sample of pharmacy claims and determined if the individual was eligible for TennCare on the dates of service according to the TennCare Management Information System (TCMIS). In addition, a nonstatistical sample of payments for legal services was examined for compliance with federal regulations.

For the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled waiver (HCBS MR/DD), we reviewed the HCBS MR/DD waiver and inquired about its operation. Key employees were interviewed at the Division of Mental Retardation Services (DMRS) for information concerning the division's responsibilities with the waiver. A nonstatistical sample of claims was selected to test expenditure allowability and claims processing and recording.

The results of this area were as follows:

- TennCare has not complied in all material respects with federal allowable cost requirements. As noted in finding 15, TennCare paid Children's Services for unallowable costs (i.e., payments for incarcerated youth, children under the age of three, and leave days). As noted in finding 16, TennCare paid Children's Services for services that are covered by and should be provided by the BHOs. As noted in finding 17, TennCare has not ensured that the Children's Services payment rates were approved. As noted in finding 18, TennCare has not adequately monitored Children's Services to ensure the allowability of costs. As noted in finding 22, TennCare has not amended its cost allocation plan, which prevented the collection of federal funds. As noted in finding 25, TennCare incorrectly used federal funds to pay capitation payments to MCOs for incarcerated adults. As noted in finding 27, TennCare does not retroactively recover all payments made on behalf of deceased enrollees. As noted in finding 30, controls over Medicare cross-over claims are weak and TennCare does not pay Medicare cross-over providers in accordance with its own rules.
- As noted in finding 26, TennCare allowed providers to submit old claims and did not pay provider claims in a timely manner.
- TennCare's supporting documentation for significant expenditure items appeared reasonable.

- Testwork revealed that amounts recorded in STARS reconciled with the amounts of checks issued and reported in federal reports.
- Significant supplemental funding pool payments were in compliance with the payment methodologies approved by the grantor. However, TennCare improperly claimed federal matching funds for premium taxes. See finding 28 for further details regarding this matter.
- TennCare does not have adequate procedures in place to provide reasonable assurance that HCBS MR/DD waiver and elderly and disabled waiver funds were expended only for waiver allowable activities as noted in finding 23.
- TennCare has not paid claims for the mentally retarded and developmentally disabled in accordance with the HCBS MR/DD waiver as noted in finding 21.
- As noted in finding 24, TennCare has not adequately monitored the payments for the pharmacy program.
- TennCare and DMRS did not have an effective formal monitoring process in place for the HCBS MR/DD waiver program as noted in findings 19 and 20.
- We determined that TennCare calculated the correct amounts to pay to the MCOs.
- We determined that TennCare paid nursing home claims correctly and these claims were pursuant to a pre-admission evaluation.
- As noted in finding 29, we determined that TennCare did not approve graduate medical education contracts before the beginning of the contract period.

Cash Management

Our primary objective for this area was to determine if management complied with the terms and conditions of the Cash Management Improvement Act Agreement between the state and the Secretary of the Treasury, United States Department of the Treasury (State-Treasury Agreement).

We tested a nonstatistical sample of federal cash drawdown transactions for compliance with the State-Treasury cash management agreement. Based on the testwork performed, we determined that management had complied, in all material respects, with the State-Treasury cash management agreement.

Eligibility

Our primary objectives were to determine whether controls over eligibility determinations and reverifications were adequate and if TennCare enrollees were eligible according to rules and regulations. Another objective of this area was to determine if recipients of Home and Community Based Services (HCBS) waiver services were eligible for services under the appropriate waiver.

We selected a nonstatistical sample of payments made on behalf of Medicaid-eligible TennCare enrollees to determine if the individuals were eligible for Medicaid/TennCare on the dates of service for which the payment was made. We used information in the ACCENT system and the TCMIS to make this determination. We also performed an assessment of internal control over eligibility for the uninsured and uninsurable population as well as for the Medicaid-eligible population.

We used computer-assisted audit techniques (CAATs) to verify whether the only payments made on behalf of "state-only" TennCare enrollees were payments to the behavioral health organizations (BHOs). (State-only enrollees are only eligible for mental health services and the cost of care is paid for with 100% state funds.) CAATs were also used to determine if these state-only enrollees' income recorded in TCMIS exceeded the maximum amounts allowed to be eligible as state-only enrollees. In addition, CAATs were used to search TennCare's payment files for payments made for TennCare enrollees with invalid social security numbers, post office box addresses, and out-of-state addresses. We also searched TennCare's payment files for full-time state employees.

We performed an assessment of internal control involving eligibility of recipients and tested payment of claims for the HCBS waivers. A nonstatistical sample was selected to test recipient eligibility for the appropriate waiver.

TennCare has not complied in all material respects with federal eligibility requirements. Testwork revealed that internal control over eligibility was not adequate for the Medicaid-eligible enrollees or for the uninsured/uninsurable enrollees. Audit testwork revealed a lack of adequate documentation to support eligibility determinations as noted in finding 9. Internal control over the eligibility of state-only enrollees was not adequate, and there were state-only enrollees that were not eligible according to the requirements. See finding 14 for further discussion.

We have noted weaknesses in internal control over eligibility for the uninsured and uninsurable population in finding 12. We also determined that TennCare did not have adequate due-process procedures in place for enrollees, and as a result, the United States district court issued a temporary restraining order (TRO). In reaction to the TRO, TennCare ceased its eligibility reverification process for the uninsured and uninsurable enrollees (see finding 8). Testwork noted that TennCare did not verify all information on uninsurable applications as noted in finding 11. In addition, CAATs revealed that TennCare made payments for TennCare enrollees with invalid social security numbers, post office box addresses, and out-of-state addresses. See finding 12 for further details regarding these matters.

As noted in finding 13, TennCare made inappropriate payments on behalf of full-time state employees. We also determined that TennCare needs to develop a court-approved plan to redetermine the eligibility of SSI-eligible individuals as discussed in finding 10. In addition, testwork revealed that there was not an adequate process in place for review and approval of documentation needed to support HCBS MR/DD waiver recipient eligibility determinations as discussed in finding 23.

Matching, Level of Effort, Earmarking
Period of Availability of Federal Funds

The primary objectives of this area were

- to provide reasonable assurance that matching requirements were met using only allowable funds or costs which were properly calculated and valued, and
- to provide reasonable assurance that federal funds were used only during the authorized period of availability.

To provide reasonable assurance that matching requirements were met using only allowable funds or costs that were properly calculated and valued, we interviewed the key personnel responsible for this function in the Division of Budget and Finance and examined selected reports. We performed testwork to determine that administrative expenditures in the State Children's Health Insurance Plan (SCHIP) did not exceed the required limits.

We obtained and reviewed documentation from the grantor concerning the approved period of availability of federal funds and compared it to total federal program expenditures. A nonstatistical sample of transactions was tested to determine if the underlying obligations occurred during the period of availability.

Based upon the testwork performed, it appeared that TennCare was complying with matching requirements using only allowable funds or costs which were properly calculated and valued. In addition, federal funds were used only during the authorized period of availability.

Procurement and Suspension and Debarment

The primary objective was to provide reasonable assurance that procurement of goods and services was made in compliance with the provisions of applicable regulations and guidelines, and that all subawards, contracts, and agreements for purchases of goods or services contained a clause stating that the contractor had not been suspended or debarred.

We reviewed the OMB Circular A-133 *Compliance Supplement* for internal control and compliance requirements for procurement and suspension and debarment and the agency program requirements under the Medicaid cluster. In addition, key employees were interviewed and walk-throughs were performed regarding TennCare's procurement of goods and services and compliance with federal requirements. We reviewed all nongovernmental contracts for $100,000 or more in effect during the year ended June 30, 2001, to determine if the contracts contained the required certifications concerning suspended or debarred parties and suspended or debarred principals. In addition, we selected a nonstatistical sample of purchases from TOPS (Tennessee On-line Purchasing System) to test for compliance with requirements contained in the OMB Circular A-133, *Compliance Supplement for Single Audits of State and Local Governments*. We also performed testwork to determine if material procurements of goods and services were made in compliance with the same policies and procedures used for the same or similar procurements from non-federal funds.

We determined that TennCare did not require all required contractors and providers to make necessary disclosures concerning suspension and debarment. See finding 32 for further information. Based on the testwork performed, however, it appeared that management had complied with other procurement requirements. Material procurements of goods and services were made in compliance with the same policies and procedures used for the same or similar procurements from non-federal funds. As noted in finding 31, TennCare made purchases that were not in compliance with federal regulations.

Program Income

Our objective was to provide reasonable assurance that program income was correctly earned, recorded, and used in accordance with the program requirements.

TennCare's program income consists of premiums paid by uninsured and uninsurable TennCare enrollees based on their income and family size. We used a nonstatistical sample of monthly capitation payments to determine if the premium amounts billed to the recipients for whom the payments were made were correct according to enrollee information in the TennCare Management Information System (TCMIS) and the premium calculation tables in the *Rules for the Bureau of TennCare.*

We also compared the total amount of premium revenue collected according to TCMIS reports and the amount recorded in the state's accounting records (STARS). In order to determine if the federal share of program income was used to reduce federal expenditures, as required, we recalculated the federal share for each quarter and reviewed the quarterly federal expenditure reports.

We determined that internal control over premiums was not adequate to provide reasonable assurance that program income was earned and recorded in accordance with program requirements, as discussed in finding 33. Based on the testwork performed, however, it appeared that premiums received were used in accordance with the program requirements.

Federal Reporting

Our objective was to ensure that reports of federal awards submitted to the federal awarding agency included all activity of the reporting period, were supported by underlying accounting or performance records, and were submitted in accordance with program requirements.

We inquired of management about the requirements and procedures for preparing, reviewing, and submitting program financial and progress reports. We selectively tested the mathematical accuracy of the reports, reviewed supporting documentation for the information presented, and determined if the reports were prepared in accordance with grant guidelines and requirements.

Based on the testwork performed, it appeared that, in all material respects, reports of federal awards included all activity of the reporting period, were supported by underlying records, and were submitted in accordance with program requirements. However, as noted in finding 24, TennCare did not maintain copies of drug use review reports.

Subrecipient Monitoring

The primary objective of this area was to determine whether subrecipients (graduate medical schools) were properly monitored to ensure compliance with federal award requirements.

We inquired of management about procedures for monitoring subrecipients, reviewed the requirements for payments to the state's four medical schools for graduate medical education, and tested the payments to determine if the amounts paid were correct. We tested TennCare's monitoring of the graduate medical schools for compliance with OMB Circular A-133. In addition, we reviewed Department of Finance and Administration Policy 22 and determined TennCare's compliance with this policy.

TennCare has not properly monitored the graduate medical schools to ensure compliance with federal award requirements or OMB Circular A-133 as noted in finding 35. Testwork revealed that TennCare did not comply with the Department of Finance and Administration's Policy 22 as noted in finding 34.

Special Tests and Provisions

Special Tests and Provisions (ST&P) consist of the following: Utilization Control and Program Integrity, Long-Term Care Facility Audits, Provider Eligibility and Provider Health and Safety Standards, and Managed Care. Each ST&P is discussed separately below.

Utilization Control and Program Integrity

Our main objectives were to determine whether the state had established and implemented procedures to (1) safeguard against unnecessary utilization of care and services, including long-term care institutions; (2) identify suspected fraud cases; (3) investigate these cases; and (4) refer those cases with sufficient evidence of suspected fraud to law enforcement officials.

Key employees were interviewed about procedures related to utilization control and program integrity. We tested a nonstatistical sample of case files in the Program Integrity Unit to determine if the appropriate steps were taken to investigate suspected cases of fraud and, if appropriate, to refer them to law enforcement officials. We also interviewed the Special Agent In-Charge of the Medicaid Fraud Control Unit, which is part of the Tennessee Bureau of Investigation.

We noted that controls were not adequate to ensure compliance with federal requirements regarding unnecessary utilization of care and services and identification of suspected fraud. In

addition to these control deficiencies, we determined that management had not complied with the *Code of Federal Regulations*, Title 42, Parts 455, 456, and 1002, which requires the state to have procedures to safeguard against unnecessary utilization of care and services. See finding 38 for more information about these matters. Based on the testwork performed, however, it appeared that noted cases of suspected fraud were properly investigated by the Program Integrity Unit, and that procedures existed to refer those cases with sufficient evidence to law enforcement officials.

Long-Term Care Facility Audits

Our objective was to determine whether the state Medicaid agency performed long-term care facility audits as required.

Key personnel at the Bureau of TennCare and the Medicaid/TennCare section of the Comptroller's Office were interviewed about compliance with audit requirements, and related documents were reviewed. We reviewed a nonstatistical sample of long-term care facility cost reports to determine if the reports had been desk-reviewed in accordance with program requirements.

We determined that controls were adequate to ensure compliance with federal and state requirements for long-term care facility audits, and that management had complied with the audit requirements.

Provider Eligibility and Provider Health and Safety Standards

Our objectives were

- to determine whether providers of medical services were licensed to participate in the Medicaid program in accordance with federal, state, and local laws and regulations, and whether the providers had made the required disclosures to the state; and
- to determine whether the state ensured that nursing facilities and intermediate care facilities for the mentally retarded that serve Medicaid patients met the prescribed health and safety standards.

Nonstatistical samples of payments to providers were tested to determine if the providers met the appropriate professional standards (e.g., were licensed in accordance with applicable laws and regulations) on the dates of service for which the payments had been made. The types of providers tested were Medicare cross-over providers, Department of Children's Services' providers, and providers for the HCBS MR/DD waiver program. We also reviewed the provider agreements to determine if they complied with federal regulations, including the disclosure requirements.

In addition, we tested a nonstatistical sample of payments to long-term care providers to determine whether the providers met the prescribed health and safety standards, and if TennCare's agreements with the facilities were in compliance with applicable laws and regulations on the dates of service for which the payments had been made.

We noted that internal control over provider eligibility and enrollment was not adequate to ensure compliance with federal regulations. However, we determined that the providers were licensed. As noted in finding 37, we determined that TennCare did not require providers to make disclosures about ownership and control information as required. Also, management did not comply with all regulations for provider eligibility, maintain documentation that long-term care providers met health and safety standards, and ensure provider agreements were in compliance with federal regulations. These matters are discussed further in finding 37.

Managed Care

Our objective was to determine whether the state operated its managed care program in compliance with the approved state plan waiver.

We reviewed the special terms and conditions (STCs) of the TennCare waiver and determined which ones were applicable for the year ended June 30, 2001. The STCs were discussed with the personnel responsible for compliance. Corroborating evidence, such as reports or other documentation, was reviewed to determine if management had complied with the STCs.

The audit revealed that controls were not adequate to ensure compliance with the STCs of the TennCare waiver, and that management had not complied with all applicable STCs. See finding 36 for more information concerning these matters.

Schedule of Expenditures of Federal Awards

Our objective was to verify that the department's Schedule of Expenditures of Federal Awards was properly prepared and adequately supported. We verified the grant identification information on the Schedule of Expenditures of Federal Awards prepared by staff in the Division of Budget and Finance, and total reported disbursement amounts were traced to supporting documentation. Based on the testwork performed, we determined that, in all material respects, the Schedule of Expenditures of Federal Awards was properly prepared and adequately supported.

Financial

Our primary objectives were

- to determine if subsidiary records of accounts receivable were properly maintained;
- to determine if the amounts recorded in the State of Tennessee Accounting and Reporting System (STARS) for accounts receivable were adequately supported;
- to determine if accrued liabilities were adequately supported and properly recorded in STARS; and
- to determine if amounts recorded as deferred revenue were appropriately classified as deferred revenue.

TennCare's accounts receivable and accrued liabilities were discussed with the personnel responsible for this function in the Division of Budget and Finance. In addition, reports, subsidiary records, and other documentation were reviewed to determine the receivable amounts. Significant receivables and liabilities recorded in STARS were traced to supporting documentation. We compared current year accounts receivable and accrued liabilities amounts to prior-year amounts and obtained explanations for significant variances. Significant individual amounts were tested for reasonableness and adequacy of support. We also discussed the deferred revenue recorded in STARS with key personnel.

Based upon the testwork performed, it appeared that the amounts recorded in STARS for accounts receivable were adequately supported and subsidiary records were properly maintained. Accrued liabilities appeared to be adequately supported and recorded in STARS correctly in all material respects. We determined that the recorded deferred revenue was appropriately classified as deferred revenue.

TennCare Management Information System General Controls

The primary objectives of this area were

- to determine if system security and system change procedures were adequate, and
- to determine whether the state Medicaid agency performed the required ADP risk analyses and system security reviews.

To accomplish these objectives, we documented system security and system change and work request procedures, reviewed related reports and manuals, and performed walk-throughs. The requirement for performing ADP risk analysis and system security reviews was discussed with the appropriate personnel.

We selected a nonstatistical sample of Resource Access Control Facility (RACF) user IDs and determined if the users' appropriate security forms were completed and on file with TennCare's security administrator, the level of access given agreed with the level of access requested, and the level of access given appeared reasonable given the employees' job responsibilities. We also tested logical security of TennCare's system to determine that usernames and passwords were required to obtain access to all screens. We also examined screens and determined if individuals with read-only access have the ability to change these screens.

Testwork revealed that system security needed improvement, as noted in finding 40. We determined that system change procedures were adequate. However, we determined that TennCare did not comply with the requirements for ADP risk analysis and system security reviews. TennCare did not have policies and procedures that covered all the areas required. In addition, TennCare did not conduct and document system security reviews on a biennial basis. See finding 41 for further details regarding this matter. Also, the TCMIS's lack of flexibility and internal control has been noted in finding 39.

Findings, Recommendations, and Management's Comments

3. Top management must address the TennCare program's numerous and serious administrative and programmatic deficiencies

Finding

As noted in the previous audit, most of the findings in this report are the result of TennCare's numerous administrative and programmatic deficiencies. Well-publicized events concerning the ability of the program to continue in its present form have contributed to the perception that the program is in crisis. Management concurred with the prior audit finding, as discussed throughout this finding. However, problems still exist.

As discussed in the "Objectives, Methodologies, and Conclusions" section of this report, the auditors are responsible for reporting on the department's internal control and management's compliance with laws and regulations material to the program. However, top management, not the auditors, is responsible for establishing an effective control environment, which is the foundation for all other components of internal control: risk assessment, control activities, information and communication, and monitoring. Under generally accepted auditing standards, control environment factors include assignment of authority and responsibility; commitment to competence; integrity and ethical values; management's philosophy and operating style; and organizational structure.

Our evaluation of the control environment and the other components of internal control revealed several continuing overall, structural deficiencies that have caused or exacerbated many of the program's problems. These deficiencies are discussed below.

Inadequate System and Staff Resources

Management concurred with the prior audit finding and stated, "We have also initiated a contract with a vendor to help us evaluate our system needs and plan for a new information system that will more adequately meet those needs." However, as discussed further in finding 39, the TennCare program still does not have an adequate information system. The program is still dependent upon a large and complex computer system, the TennCare Management Information System (TCMIS), that is outdated and inflexible.

Management also stated in response to the prior audit finding:

> Our new Deputy Director. . . has been on the job since June 2000. Our Chief of Operations, who is also Deputy Director of TennCare, has been on the job since February 2000. . . . We have a new TennCare Partners Program Operations Director, who has been on the job since August 2000. . . . We now have a Manager of Personnel. . . . A new Director of the Solutions Unit has recently been hired. . . . A staff reorganization is in the final planning stages, and recruiting is underway for additional positions that will head up both MCO operations and Member Services. Reorganization, function assignments and

> departmental personnel resource allocation is underway for the entire Bureau. . . . There will be changes made in some operational areas based on operational needs, unit function and departmental statewide responsibilities. Another significant organizational change that has occurred in the past year has been the establishment of the Office of Health Services, headed by the Deputy Commissioner.

However, according to management, the TennCare program is still understaffed. During fieldwork, we did note attempts by management to hire additional staff.

Inadequate Written Operating Policies and Procedures

Management stated in response to the prior audit finding that "written policies and procedures have been developed for the following units: Administrative Appeals, TennCare Information Line, Provider Services, Legislative Response." However, despite its size and complexity, TennCare still does not have adequate written operating policies and procedures. As previously noted, the lack of written, comprehensive operating policies and procedures increases the risk that errors or inconsistencies may occur in the TennCare program. For example:

- A TennCare eligibility policy and procedures manual has not been approved for the County Health Offices (CHOs). See finding 12 for further details.
- TennCare's policies and procedures manual for pricing cross-over claims is not adequate. See finding 30 for further details regarding this matter.
- TennCare has no written, comprehensive operating policies and procedures pertaining to utilization control and suspected fraud (finding 38).
- There were no written procedures during the audit period for Financial Change Requests as discussed in finding 6.
- TennCare's fiscal agent, EDS (Electronic Data Systems), is responsible for entering adjustments in the TennCare Management Information System (TCMIS) for fee-for-service claims. The adjustments are entered using Adjustment/Void Request forms. EDS staff including the supervisor key in adjustments based upon the forms. The supervisor then randomly reviews these adjustments keyed by others. However, testwork revealed that there was no review of the changes that were keyed into TCMIS by the supervisor.

Inadequate Due Process Procedures for Enrollees

TennCare did not have adequate due process procedures in place for enrollees. Please see finding 8 for further details regarding this matter.

Inadequate Monitoring

TennCare's monitoring effort needs improvement see findings 4, 18, 19, 34, and 35 for further details.

In addition, as noted in the prior two audits, in its August 9-12, 1999, site visit report, the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration stated,

> Although we have brought this to the attention of State officials on multiple occasions, we found that Tennessee has not developed a comprehensive plan for monitoring the TennCare program. Tennessee does have some activities in place for monitoring; however, Tennessee needs a plan that incorporates these activities and any other activities that the State may develop for long-term monitoring for the life of the project (i.e., TennCare). This plan should incorporate the monitoring of the TennCare Partners program.

Concerning the TennCare Monitoring Plan, management stated in response to the prior audit finding, "We are reviewing this plan and taking steps to determine whether there should be changes before we implement." However, TennCare still does not have a monitoring plan in place.

Recommendation

For the TennCare program to improve and succeed over the long term, the Director of TennCare and his staff must address the long-existing problems within and external to the administrative structure of the program.

The Director should also develop a plan to address the personnel requirements of the program. The plan might include cross-training, employee development, emphasizing employee career-paths, staff reassignment, and workload redistribution. In addition, the Director should continue to pursue acquisition/development of a new TennCare information system.

The Director should ensure that adequate written and comprehensive operating policies and procedures are developed for all areas of the TennCare program. The Director should ensure adequate review of all adjustments that are made to fee-for-service claims in TCMIS. The policies and procedures should be clearly communicated to all program employees, and responsibility for updating the policies and procedures, as well as distributing the updates, should be assigned to the appropriate staff.

Finally, as previously noted, the Director should develop and implement the comprehensive monitoring plan requested by the grantor. The internal auditors also could be used to help to implement the monitoring plan or to ensure that the plan is being implemented properly by others.

Management's Comment

TennCare concurs with the overall finding. Significant energy has been invested in addressing these issues, but many of these issues require substantial planning and development. The results of these efforts are obvious in a number of areas, but still need development in others. Overall internal controls are being upgraded.

TennCare concurs that it still does not have an adequate information system to meet the business demands it faces. Significant progress has, however, been made on changing this. The Bureau has invested a year in developing a procurement for a replacement TCMIS. This development process included many users and constituents, including other state agencies and affected outside parties. The procurement is expected to be public before the end of March 2002. The new system is to be implemented by October 1, 2003. This procurement has substantial new requirements for administrative and programmatic monitoring of the system processes. The contractor will develop new operations and procedures manuals. All documentation, as well as policies and procedures, will be accessible by approved users electronically. The system will have a flexible table-driven design to quickly respond to new policy and regulatory changes. The system will facilitate compliance with all federal and state laws and regulations. Audit trails will be provided throughout the system to identify and track all transactions (e.g., eligibility changes, claims adjustments). The system will retain the fields changed, reason, source, date, time, and previous transaction information.

A second procurement for a decision support system (DSS) will follow in a couple of months. This system will permit greater flexibility and access to TennCare data. It will permit business users to analyze data that affects their units without requiring ad hoc reports from the operating system.

In the meantime, the Bureau has added a new appeals tracking system with substantial data analysis capabilities. This new system now permits detailed tracking of appeals activity and detailed analysis of appeal issues. The system was fully implemented for medical appeals November 1, 2001, and should be fully implemented in administrative appeals by June 2002.

Significant changes have also been made in staffing. A number of new positions have been hired into the Bureau. Staffing shortages still occur when appeals volumes peak, but overall staffing is substantially improved. The organization has also been restructured to include a stronger senior management structure. A new assistant commissioner for member services has been established to coordinate all activities directed at members, including eligibility policy, the member hotline, administrative appeals, and medical appeals. A new assistant commissioner for delivery systems has been hired to coordinate all of the ways in which TennCare delivers services, including the MCO program, behavioral health, pharmacy, dental, and long term care. In addition, a separate MCO program director has been created to coordinate all interaction with MCOs.

The Bureau has made substantial progress on developing operating policies and procedures. All of TennCare's eligibility and reverification procedures have been rewritten. A

detailed manual has been created for the Department of Health staff. A comprehensive waiver operating protocol has also been created to coincide with the implementation of the new waiver. We have documented MCO and BHO contract and oversight responsibilities and linked these responsibilities to the contracts paragraph by paragraph. Procedures for MCO/BHO financial and claims reviews have been established jointly by the Bureau and Tennessee Department of Commerce and Insurance (TDCI). Monthly MCO/BHO performance reviews have been established to review all available performance data.

4. TennCare should ensure adequate contracts and effective monitoring of contracts

Finding

As noted in the two previous audits, the Bureau of TennCare needs to ensure adequate contracts and effective monitoring of contracts. As reported since 1999, the Bureau of TennCare has not had an interdepartmental agreement with the Department of Commerce and Insurance (Commerce and Insurance) and has an out-of-date cooperative agreement with the Department of Human Services (DHS). Furthermore, the Bureau has not effectively monitored its contracts.

Management concurred with the prior audit finding and stated that they would assign a specific individual to each contract and that monitoring would be a priority. Management did assign specific staff members responsibility for monitoring all Bureau contracts. Management also stated that they would assign a staff member to work with TennCare staff, the Department of Children's Services (DCS), and monitors in the Department of Finance and Administration to improve the monitoring effort for DCS. However, testwork revealed that the monitoring effort needs improvement. See finding 18 for further details on this matter. Management also stated that they would review the agreement with DHS and initiate an agreement with Commerce and Insurance, but that the agreements would not be completed before the end of the fiscal year ending June 30, 2001. The Bureau did develop an interdepartmental contract with Commerce and Insurance by July 2001. In accordance with the TennCare Waiver, the Department of Commerce and Insurance, TennCare Examiners Division, is responsible for conducting examinations of managed care organizations (MCOs) and behavioral health organizations (BHOs) that contract with the Bureau of TennCare. Commerce and Insurance conducts these examinations of MCOs and BHOs to ensure financial viability and compliance with statutory and contractual provisions, and rules and regulations.

The Bureau of TennCare's cooperative agreement with DHS is for the determination of Medicaid eligibility. The agreement has not been revised or amended since October 1969, when the original agreement started. The TennCare program was implemented in January 1994 after the state obtained a waiver from the federal Health Care Financing Administration which allowed the state to replace its basic Medicaid program with a managed care system. Since the agreement has not been revised or amended since 1969, the unique features of the TennCare program are not included in the agreement. Furthermore, the cooperative agreement does not provide sufficient detail to ensure that all parties are fully informed of the relevant scope of services and related responsibilities. The agreement states that the Department of Public Welfare (currently

known as the Department of Human Services) assumed responsibility for "the determination of eligibility" for Medicaid recipients. However, the agreement does not provide details concerning which policies, standards, or methods should be used to make the eligibility determinations.

In addition, testwork revealed that the contract between TennCare and the DCS does not specify which policies, standards, or methods DCS should use to make eligibility determinations for the Title XIX program. Not including this information in the contracts increases the risk that DCS is not using the correct eligibility criteria in making its eligibility determinations.

Also, discussions with the Chief Financial Officer revealed that TennCare did not conduct fiscal audits of the external quality review organization (EQRO) contractor as required by the contract with the EQRO contractor.

Furthermore, TennCare has not developed monitoring procedures. Although TennCare has assigned responsibility for each contract, testwork revealed that sufficient monitoring procedures for each contract were not performed. Examples of these contracts and agreements include

- an interdepartmental contract with the Department of Commerce and Insurance to conduct examinations of the MCOs and BHOs to ensure financial viability and compliance with statutory and contractual obligations;
- a contract with the Department of Human Services to provide Medicaid eligibility determinations;
- a contract with the Department of Children's Services to provide non-medical treatment and case management services (see finding 18);
- a contract with the Department of Health's Office of Health Licensure and Regulation to certify healthcare facilities;
- a contract with the University of Tennessee-Memphis and Erlanger Medical Center/T.C. Thompson Children's Hospital in Chattanooga to conduct a high-risk regional perinatal program; and
- a contract with East Tennessee State University in Johnson City, Meharry Medical College in Nashville, University of Tennessee-Memphis, and Vanderbilt University in Nashville to provide graduate medical education (see finding 35).

Without effective monitoring procedures in place, the Bureau cannot ensure compliance requirements of each contract are being met.

Recommendation

The Director of TennCare should revise the cooperative agreement with DHS to ensure that all parties are fully informed of the scope of services and specific responsibilities. This agreement should be revised to reflect the TennCare program and the rules that govern the

program. The Director should revise the contract with DCS to specify which policies, standards, or methods DCS should use to make eligibility determinations. The Director should ensure that TennCare conducts fiscal audits of the EQRO contractor as required. In addition, the Director of TennCare should ensure that adequate contract monitoring is performed and that written policies and procedures are developed and implemented as necessary to ensure effective contract monitoring is performed.

Management's Comment

We concur in part. A new agreement with the Department of Human Services is now in place. With respect to eligibility determinations, the agreement with the Department of Children's Services (DCS) states that DCS agrees to "perform TennCare eligibility determinations in accordance with Medicaid eligibility criteria . . ." In another section of the contract, applicable laws, rules and policies are cited.

We concur that the contract with the external quality review organization states that TennCare's responsibilities include a fiscal audit of the contractor and that this review was not performed. The contract was entered into through the State's bid process and the contractor is paid on a unit rate/milestone methodology as opposed to a reimbursement methodology. While TennCare may audit this contractor, because of the nature of the payment methodology, a fiscal audit of this type contract would not normally be performed. A determination will be made as to whether a fiscal audit is warranted.

TennCare will continue to work with the Department of Finance and Administration, Program Accountability Review section to refer appropriate contracts for monitoring. A process to identify contracts that should be monitored has been developed; this process is performed at the time the contract is executed. After additional evaluation, other procedures considered necessary will be implemented within the Bureau to ensure appropriate monitoring is performed.

Rebuttal

With respect to DCS eligibility determinations, management's quote from the contract relates to the new DCS contract for "the period commencing on July 1, 2001, and ending on June 30, 2003." The contract that was in effect during the audit period contained no such statement. The new DCS contract also has a section titled "Applicable Laws, Rules, and Policies." However, the contract in effect during the audit period does not have a section that lists applicable laws, rules, and policies.

5. The Department of Finance and Administration did not exercise its responsibility to ensure that the Department of Human Services maintained adequate system security over the ACCENT system

Finding

The Department of Finance and Administration did not ensure that the Department of Human Services (DHS) maintained adequate system security over the Automated Client Certification and Eligibility Network (ACCENT). While the Department of Finance and Administration (F&A) does not have the day-to-day responsibility for the ACCENT system, the accuracy and integrity of the data in the TennCare Management Information System (TCMIS) is ultimately dependent upon system controls present in both the TCMIS and the ACCENT system. Under a cooperative agreement with the Bureau of TennCare, DHS is responsible for determining Medicaid eligibility for the state. DHS uses the ACCENT system to determine eligibility for Medicaid-eligible recipients and sends ACCENT records to the Bureau of TennCare in the Department of Finance and Administration daily to update eligibility information in TCMIS. Since TennCare relies upon DHS to make eligibility determinations for Medicaid, it is critical that F&A ensures adequate system controls exist for the ACCENT system.

During the audit for the fiscal year ended June 30, 2001, we noted terminated employees' access privileges were not revoked in a prompt manner; and security authorization forms were missing, were not properly completed, or did not match the current access privileges of the users.

Terminated employees' access privileges were not revoked in a prompt manner

Testwork noted 5 of a sample of 38 Resource Access Control Facility (RACF) users, who possessed active ACCENT privileges, (13%) were terminated users. RACF is the state mainframe security software, which is used to provide an initial level of access security before the user can access department- or agency-level systems. Good security practices require that terminated users' system privileges within all applicable systems are promptly revoked upon their termination. The failure to revoke terminated users' system privileges increases the possibility that sensitive information could be inappropriately modified.

Authorization forms were missing, incomplete, or inconsistent with users' actual access rights

Testwork noted the following issues:

- Department personnel were unable to locate RACF security forms for 3 of 38 users (8%) who had active access rights to the ACCENT system.
- Eleven of 25 ACCENT security authorization forms selected for testwork (44%) were not properly authorized by management.
- Five of 25 ACCENT security authorization forms selected for testwork (20%) did not match the actual access levels possessed by the employees. All five users possessed greater access than originally authorized.

Good security practices require that an access authorization form should be completed for each employee using departmental or state application systems. This authorization should be prepared by the employee's management, and should specify the employee's access level(s) and the justification for such access. If the access privileges required by an individual legitimately change, a new authorization form should be completed prior to the changing of the access rights by the security administration staff. All of the completed authorization forms should be maintained in a secure location by appropriate security administration personnel. The failure to prepare, collect, and maintain access authorization forms as suggested above increases the possibility that access to sensitive systems and information may be granted to ineligible individuals, and that authorization may be granted to employees in excess of what is warranted for their job responsibilities.

Recommendation

The Commissioner of Finance and Administration should ensure that DHS Management improves security for ACCENT. The Commissioner of Finance and Administration should ensure users are granted the appropriate level of system access based on their job responsibilities. Security authorization forms should be completed by management and maintained. The Commissioner of Finance and Administration should monitor the system security for ACCENT and take appropriate action if problems are noted.

Management's Comment

Department of Finance and Administration

We concur in part. However, to maintain data integrity, the TennCare TCMIS regularly receives and validates data from the DHS ACCENT system. This validation includes format and limitations review. TennCare staff inspects a portion of the data from ACCENT within 24 hours of receipt of the data to verify the accuracy of that data and reports back to DHS when the information is not acceptable.

We concur that there are external agencies who have access to the TCMIS. We have aggressively attempted to obtain signed justification for users in those agencies. TennCare Information Systems management has reviewed security forms based on previous audit findings and modified the forms to include justification. As new users were granted access to the TCMIS, the new justification form was submitted. In addition, in cases where justification forms for existing users could not be located, justification was requested from section managers and the security forms were updated. We are currently in the process of obtaining justifications from users in the Department of Human Services (DHS).

The current TCMIS has many controls and edits included which allow for extensive internal access control and audit capabilities. However, TennCare Information Systems management will concede that external access control from other state agencies such as Department of Health (DOH) and Department of Human Services (DHS) could be improved.

Therefore, Information Systems is currently in negotiations with DOH and DHS to develop a no-cost inter-departmental contract that will include enhanced procedures to control access to the TCMIS. The execution of these contracts will provide administrative procedures and controls over access to the MIS as well as provide for audits by the comptroller.

Department of Human Services

We concur.

The Department continues to work on the detailed processes that are necessary in order to put in place the larger improvements in our security controls that are more visible in audit reviews. Security Administration Focus Group staff have continued to work toward integrating security management controls with ACCENT so that we can properly authorize and terminate user access to this system. As we move toward department-wide access control procedures, the following outlines our plan to ensure that ACCENT user tables have integrity, and to integrate effective access control procedures for these systems.

A target date of March 2002 has been set to pilot implementation of the new department-wide access control procedures for Family Assistance and Field Operations staff. We will pilot the procedures in one of our eight administrative districts. Under the new procedures:

- All user profiles will be added to RACF and ACCENT (i.e., created and/or changed) by Central Office security staff. All subsequent changes that are made by field staff require the submission of a new form that explains the permanent change in access.
- One form will be used to apply for a User ID and authorize access to ACCENT.
- The authorization form will be sent by designated management staff and approved by Central Office security administration staff based on established policies and procedures. A new authorization form must be sent for all changes, and procedures will be put in place to detect unauthorized changes. All authorization forms will be stored centrally. Upon termination of employment or a change in work groups, users will automatically be terminated on ACCENT.
- A training package is being finalized for all users; managers who are designated as being responsible for requesting access; and security staff who are responsible for granting and terminating access to ACCENT. The training packages will be completed for the pilot in March 2002.
- Plans are to expeditiously implement the new procedures in all of the other program areas after the Family Assistance and Field Operation work groups.

Terminated employees' access privileges were not revoked in a prompt manner.
Authorization forms were missing, incomplete, or inconsistent with users' actual access rights.

In January 2002, we implemented a new screen in ACCENT to eliminate the need for Family Assistance Field and State office staffs who require multiple ID's on ACCENT to have multiple user profiles on RACF. The SMUG screen also allows security staff to view the ID's

that an individual has active in ACCENT, and inactivate them when employment is terminated or the user leaves the work group.

Also, we began generating and using reports that enable security staff to review the ACCENT user data table to review users who have multiple active ID's and detect profiles that allow specific access authorizations that are not consistent with the user's job title. In all instances, the appropriate manager is responsible for ensuring that the authorized profile is consistent with the user's job responsibilities, which may not be consistent with the user's job title. This point will be stressed in the training for designated managers.

In addition, a department-wide memorandum was issued with a checklist of things to be done when an employee leaves the department. The memo was issued so that each supervisor or manager knows all that is expected of them after an employee leaves the department. The termination of computer access is among these items.

Rebuttal

While the procedures described by management could provide for the validity of data, it is still imperative that management improve system security by granting appropriate access based on job responsibilities.

6. Controls over financial change requests should be strengthened

Finding

As noted in the prior audit, the TennCare Bureau needs to improve controls and policies over financial change requests (FCRs). Management concurred with the prior audit finding and stated that TennCare "will review controls and procedures over FCRs and implement changes as needed." However, testwork revealed that the controls and procedures were still inadequate. Although TennCare implemented some controls over FCRs on April 1, 2001, in response to the prior audit finding, testwork revealed that the controls implemented were not adequate.

FCRs are used by the Bureau to make adjustments or corrections to payments made to providers. Electronic Data Systems (EDS), the fiscal agent, is responsible for keying FCRs into the TennCare Management Information System (TCMIS). The following deficiencies were noted during the audit:

- There were no written procedures for the FCR review process implemented on April 1, 2001.
- TennCare does not examine system reports for adjustments that are not supported by FCRs. Without this examination, there is a possibility that adjustments could be entered into the system without authorization.

- One of 60 FCRs sampled had not been signed by all the required individuals and had not been correctly entered into TCMIS. The FCR requested a recovery from a provider of $25,340; however, only $25,240 was recovered. Discussions with management revealed that this under recovery was made because of an oversight.

These weaknesses in internal controls over FCRs could permit unauthorized payments to be made and not be detected in the normal course of business.

Recommendation

The Director of TennCare should ensure written procedures are developed and followed for the FCR review process. These procedures should include requirements to examine system reports for unsupported adjustments and should require all examinations to be documented.

Management's Comment

We concur. The Bureau developed a procedure that went into effect in April 2001 related to financial change requests and will ensure that it addresses these issues. This procedure instructs the fiscal staff involved in initiating an FCR to sign off at the bottom of the FCR as final approval of completion. The sign off completes the FCR process by verifying what was requested was done accordingly and correctly. An addition to the procedure was written and implemented in October 2001, which created another internal control for verifying each FCR has been completed and that no financial transactions occurred that were not requested in an FCR document. The fiscal staff member responsible will tick mark each line 13 and line 16 transaction shown on the report. These lines indicate the financial transaction was initiated by an FCR. These written procedures were put in place to strengthen controls over the FCR process.

7. TennCare did not follow its own rules that were in effect during the audit period

Finding

As noted in the prior five audits, the Bureau of TennCare has not followed several of the departmental rules it has created. Among the reasons cited for bypassing the rules were that some rules were out-of-date and no longer addressed the situation and that adherence to some of the rules was not feasible. Management has revised its rules. However, they were not effective for the audit period.

Testwork revealed the following recurring discrepancies:

- The Bureau is paying some providers more than is allowed by departmental rules. The method used to calculate outpatient hospitalization payments to providers caring for enrollees who are both TennCare and Medicare recipients sometimes results in

payments that exceed limits. Audit testwork revealed payments that exceeded the limits. (See finding 30 for more details.) In the prior audit finding, management stated these rules had been revised. Although the rules have been revised, the rules were not effective until November 4, 2001.

- The Bureau has drafted rules to include changes in the method it uses to determine payments to the state's medical schools for graduate medical education. Management stated in the prior finding that the rules would be drafted when the waiver is extended. While management did draft rules, these rules were not effective during the audit period.
- The revised rules pertaining to the Home and Community Based Services waiver program were not effective during the audit period to reflect the changes in the program. For example, TennCare no longer pays provider claims based on a per diem rate. In the prior audit finding, management stated that rules were being amended to include language to comply with the Grier Consent Decree Order. The rules were effective September 19, 2001.

Recommendation

The Director of TennCare should ensure that the modified rules pertaining to payments for enrollees who are both TennCare and Medicare recipients as well as the Home and Community Based Services waiver program are followed. In addition, the Director should ensure the draft rules pertaining to graduate medical education are made effective.

Management's Comment

We concur. New rules have been implemented since the end of the audit period for Medicare/TennCare cross-over claims and the HCBS waiver program. New rules for the GME program are under review and will be put in place as soon as possible.

8. TennCare did not have adequate due process procedures in place for enrollees, and as a result, the United States District Court issued a Temporary Restraining Order

Finding

Although TennCare has been in operation since January 1, 1994, TennCare did not have adequate due process procedures in place for enrollees to protect their rights when denied services or terminated from the program. As a result, on May 5, 2000, the United States district court issued a Temporary Restraining Order (TRO). In reaction to the TRO, TennCare did not terminate any uninsured or uninsurable member for any reason other than a voluntary termination per the member's request or by death. In addition, TennCare stopped mailing out reverification notices in November 2000, which ceased the face-to-face reverification process. However,

having adequate due process procedures in place for enrollees could have prevented the TRO and would have allowed TennCare to continue the reverification process.

During the fiscal year ended June 30, 2001, TennCare did terminate enrollees who requested in writing to be disenrolled and enrollees that died. On February 9, 2001, the court lifted a portion of the TRO when court-approved policies and procedures are followed for terminating incarcerated persons, enrollees with access to insurance coverage from other sources, and individuals who are no longer residents of Tennessee. Procedures were placed in operation during the year ending June 30, 2001, to identify and terminate incarcerated persons. In addition, procedures were placed in operation during the year ending June 30, 2001, to identify enrollees who have access to insurance coverage from other sources, and procedures were placed in operation to terminate these enrollees after the audit period. Procedures to identify or terminate individuals who are no longer residents of Tennessee were not placed in operation until after the end of the audit period.

On March 12, 2001, an Agreed Order and a Settlement Agreement were entered into. According to management, when all the requirements in the Agreed Order and Settlement Agreement are met, TennCare will start reverifying uninsured and uninsurable recipients. Per discussion with management, as of November 14, 2001, the requirements in the Agreed Order and Settlement Agreement have been met, and the Court has approved TennCare's process for reverification.

Recommendation

The Director of TennCare should ensure that adequate due process procedures for enrollees continue to be in place. Now that a court approved plan is in place the Director of TennCare should ensure that enrollees are reverified annually. Enrollees who are found to be ineligible through the reverification process should be removed from TennCare's roles. The Director should ensure that the process approved by the court for due process and terminations is followed.

Management's Comment

We do not completely concur with the finding but recognize the importance of ensuring due process for our enrollees. Decisions that were made regarding compliance procedures that we have implemented in light of the *Rosen* Order were effectuated upon advice from the Office of the Attorney General. TennCare has worked diligently to revise policies and procedures to comply with the federal and state regulations. We have worked with plaintiffs' counsel to attempt to ensure that the revised policies and procedures met with the approval of the court. We continue to meet with the Attorney General's office and plaintiffs' counsel weekly to improve our system and address any issues that are identified. We believe that we have in place monitoring mechanisms that will alert us immediately as to any new issues that may arise and the ability to address them forthwith.

With agreement of the Court and Plaintiffs' counsel, the first 10,000 reverification notices were mailed by year-end 2001. Of the initial 500 enrollees who have kept their appointments and been reverified, only 12 have been determined to be ineligible. These enrollees will be notified and advised of due process appeal rights in accordance with federal rule (42 C.F.R. §431 Subpart E). The second mailing of reverification notices has recently been mailed to an additional 25,000 enrollees. These and all others, where adverse decisions may result, will be afforded all due process safeguards. The Bureau will monitor this process and bring the level of reverification notices to 40,000 per month.

The local Departments of Health are being provided detailed Desk References to assist in processing reverifications. The process will be monitored to assure quality compliance. Effective September 19, 2001, additional rules concerning this process have been promulgated.

Auditor's Comment

It is not clear from management's comment with which part(s) of the finding management does not concur. As indicated in the finding, a U.S. district court determined that TennCare did not have adequate due process procedures. Management appears to agree with the part of the recommendation concerning reverification and termination as evidenced by corrective actions for reverification and termination stated in management's comment.

9. TennCare did not require the Department of Human Services to maintain adequate documentation of the information used to determine Medicaid eligibility

Finding

The Bureau of TennCare did not require the Department of Human Services (DHS) to maintain adequate documentation of the enrollee's information used to determine Medicaid eligibility. The Department of Human Services performs Medicaid eligibility determinations under the cooperative agreement with the Bureau of TennCare. Testwork has revealed that this agreement is not adequate. See finding 4 for further details on this matter.

DHS uses the Automated Client Certification and Eligibility Network (ACCENT) system to determine eligibility for Medicaid. During the enrollment process, county DHS eligibility counselors meet with the potential enrollees in face-to-face interviews. Each applicant is required to provide hard copy documentation to support various eligibility criteria. This information includes income, resources, medical expenses, family information, social security numbers, date of birth, etc. During the enrollment process eligibility counselors examine documentation supporting the information that is entered into ACCENT. For example, before entering income into the system, an eligibility counselor would examine such documentation as employment pay stubs or federal tax returns. At the end of the enrollment process, the documentation supporting the information entered into the system is then returned to the

applicant/enrollee. ACCENT makes the eligibility determination based upon the information entered into the system by the eligibility counselor.

DHS transmits eligibility updates from ACCENT daily to the Bureau of TennCare to update TennCare eligibility information in the TennCare Management Information System (TCMIS).

Testwork revealed that the enrollee's application is the only paper documentation consistently kept by DHS. Although ACCENT maintains electronic case notes, there is no documentation kept to support the eligibility information entered into ACCENT. Without adequate documentation of the information entered into ACCENT, the risk is increased that ineligible enrollees may be enrolled on Medicaid.

Discussions with management at DHS revealed that the department relies heavily upon information from the Tennessee Department of Labor and Workforce Development, the Social Security Administration (SSA), the Tennessee Department of Health, and the Internal Revenue Service (IRS) for verification of eligibility information. From the Department of Labor and Workforce Development, DHS receives monthly data on Unemployment Insurance Benefits that can be used to verify unemployment income.

DHS also receives monthly beneficiary and earnings data, daily social security number verification, and daily information on Supplemental Security Income (SSI) recipients from SSA. The data from SSA provide DHS a method of verifying an individual's Social Security payments, social security number, Medicare eligibility status, and SSI eligibility status. Through the Office of Vital Records within the Department of Health, DHS has daily access to birth records. This information can be used to verify ages and relationships needed when making an eligibility determination. DHS also receives wage data from the Department of Labor and Workforce Development. However, not all employers are required to report employee wages to the state. Employers that are not required to report include churches regardless of the size of payroll or number of employees and non-government organizations with a small payroll and/or few employees. Furthermore, this information is sometimes several months old and is reported on a quarterly basis. Medicaid eligibility is determined based upon current monthly income. In addition, the income data DHS receives from the IRS that is reported on an individual's IRS 1099 form is delayed several months and is reported on a yearly basis.

Although DHS receives information from outside sources, not all eligibility requirements can be verified through this information. These outside information sources do not provide a systematic way to verify all types of income an enrollee might have. In addition, none of the updates received from other departments include documentation of other resources for non-SSI recipients or medical expenses that could affect an eligibility decision.

Without maintaining the documentation, the Bureau of TennCare cannot ensure that the information entered into ACCENT is accurate and Medicaid enrollees are eligible. Not maintaining this documentation also reduces accountability for information entered and makes researching cases more difficult.

Discussions with management at the DHS also revealed that the department relies heavily on quality control processes used to monitor the accuracy of information in ACCENT and the eligibility determinations made. Quality control personnel select samples monthly of Medicaid and Food Stamp eligible individuals. The unit verifies the information entered in ACCENT with outside sources. They also select a sample of denied cases to ensure that the person was appropriately denied. Although these quality control processes could provide some assurance that the information in ACCENT is accurate, testwork on the quality control procedures revealed the following weaknesses:

- For Medicaid eligible enrollees the department does not include all Medicaid eligible enrollees in the population sampled.
- The treatment of dropped cases needs improvement. Dropped cases include mainly cases that are not pursued by the department because the enrollee either fails or refuses to cooperate or the department is unable to locate the individual. While the department does replace dropped cases with additional cases, it does not count them as errors. Excluding those cases from the error rate of the review could affect the results of the reviews. For example, the error rate of the sample could be higher or lower based upon the results of the dropped cases. Maintaining documentation provided by the applicant during enrollment would allow the department to test all cases selected. The department should no longer have the problem of being unable to locate the enrollee or obtain cooperation of the enrollee.

Not having adequate quality control procedures and using these control procedures as a substitute for keeping the documentation increases the risk that inaccurate information is used in making eligibility determinations and increases the risk that incorrect eligibility determinations are made.

Recommendation

The Director of TennCare should ensure that DHS keeps documentation of the information entered into ACCENT that is used to determine Medicaid eligibility. TennCare's contract with DHS that is currently being developed should include requirements for DHS to keep the needed documentation. While it might be possible to reduce the amount of documentation needed with an effective quality control process, documentation should still be maintained for areas of higher risk of ineligibility as determined by the quality control efforts. At best a quality control system is an after the fact determination of eligibility. It is important that the department be able to support eligibility determinations at the time benefits are awarded.

If management wishes to reduce the level of documentation maintained by reliance on a quality control process, that process should adequately cover the entire Medicaid eligible population and it should consider any unsupported eligibility determinations to be errors and appropriately project such results to the population.

Management's Comment

Bureau of TennCare

We do not concur. Approval of the ACCENT system design, which includes the electronic recording of eligibility data, was obtained from the U.S. Department of Health and Human Services before implementation of the system in 1992. There has never been any indication from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, that the process in place was not adequate to meet federal requirements. In addition, the State Attorney General also issued an opinion in 1992 that the use of an electronic eligibility file and the application form satisfied legal requirements for determining eligibility.

As required by federal law and to ensure program integrity, the Department of Human Services (DHS) has had a quality control system in place since implementation of TennCare (and previously under the Tennessee Medicaid program). In this quality control system, called Medicaid Eligibility Quality Control (MEQC), each month DHS uses a random sampling of Medicaid cases to validate eligibility determinations, whether active (eligible) or negative (denied). The MEQC system is designed to reduce erroneous expenditures by monitoring eligibility determinations, third party liability activities, and claims processing (State Medicaid Manual, Part 7, Quality Control). MEQC programs approved in Section 1115 waiver states are relieved of any liability for disallowances for Medicaid eligible enrollees and for individuals added under the waiver resulting from errors that exceed the 3 percent tolerance level established by federal regulations.

TennCare believes that the eligibility procedures, including the level of documentation, and the MEQC reviews and follow-up activities provide adequate internal controls over the eligibility process and meet federal requirements. However, consideration will be given as to whether any additional monitoring of the process in place at DHS should be performed.

Department of Human Services

We do not concur.

The ACCENT system has been operational since 1992. For ten years, two departments of the federal government (the Department of Health and Human Services and the Department of Agriculture) have provided significant federal funds to support Tennessee's eligibility determination process for three programs: Food Stamps, Families First (formerly Aid to Families with Dependent Children or AFDC) and Medicaid. The affected federal agencies are also concerned about the integrity of their programs. By approving the ACCENT system, these agencies recognized that the method of eligibility documentation employed by ACCENT met their high standards. They have never expressed any concern regarding a lack of adequate documentation to verify the accuracy of information entered in ACCENT following the certification of the system.

The Department of Human Services is the single state agency for both Food Stamps and Families First. The Bureau of TennCare (Department of Finance and Administration) serves as the single state agency for the Medicaid program. Both federal agencies concurred in the design and development of the ACCENT system. Without federal approval there would have been no federal funding of either the ACCENT's development or program service funding since 1992.

Federal funding for ACCENT has been consistent for both system development and ongoing eligibility processing. The "closeout" letter from the Department of Health and Human Services dated February 9, 1995, is evidence of the approval of both AFDC and Medicaid program participation. This letter represents the final approval and certification of the ACCENT system. There are also letters from USDA approving ACCENT functionality. USDA was well aware of the "paperless" aspects of the system.

A memorandum dated December 8, 1992, was received from Tennessee's Office of the Attorney General providing an informal legal opinion regarding the legal sufficiency of maintaining a one-page paper application and an electronic case file. The opinion was that "the application form and the electronic file satisfies the legal requirements for determining eligibility and would be admissible evidence in legal proceedings regarding such eligibility." The opinion further states that "[t]here are no federal requirements specifying that the Department of Human Services maintain written documentation other than the signed application form."

Traditionally, as part of the funding agreement and program oversight, the federal agencies require a Quality Control system to review a sample of case actions. Currently only the Food Stamp program requires that a complete Quality Control review be conducted as part of the federal/state funding agreement. For the Medicaid program, the state and the federal agency mutually target a portion of the Medicaid population for a Quality Control review with a corrective action plan as the goal for improving case quality. For both the Food Stamp and Medicaid programs, there is a random case selection sample each month. This sample is made from the list of all Food Stamps households or all Medicaid cases with children (current Medicaid QC plans) as applicable. The Medicaid QC covers all assistance groups with children except those that are Families First related and 80% of the Families First cases are subject to the Food Stamp QC sample. Please note that with the Food Stamp program there is a federal re-review using a sub-sample of the state QC review cases. The Food Stamp federal review is conducted electronically by reading the ACCENT record and the QC review packet.

Based on a sample of Medicaid cases (an average of 35 cases per month), the Quality Control system ensures that the electronic file includes the required information for eligibility determinations and verifies the accuracy of that information. Further, the Quality Control system serves as a deterrent to creating fraudulent cases/documentation. Contrary to what is stated in the finding, the Quality Control reviewer must independently verify all points of eligibility. The Quality Control process ensures that the verification sources (primary, secondary, or others) used by the eligibility counselor are appropriate. The eligibility counselor must rely on a variety of sources to correctly determine eligibility. Depending on the source (bank statement, pay stub, birth certificate, self-declaration), the eligibility counselor must obtain further verification. While it is true that there are numerous online matches with a variety of agencies (Social Security

and Department of Labor), these sources only serve as indicators and additional verifications must be pursued. Quality Control oversight provides on-going assessment of worker skill and knowledge in establishing financial eligibility and verifies that the information entered into ACCENT is accurate.

The plan for selecting certain categories of Medicaid for review is determined between state TENNCARE program staff and the U.S. Department of Health and Human Services Center for Medicaid Services. In the absence of specific federal guidelines for Quality Control on Medicaid cases, we follow the Quality Control guidelines for the U.S. Department of Agriculture Food Stamp program.

There appears to be concern about the Medicaid Quality Control process based on the statement in the audit finding that "The treatment of dropped cases needs improvement." This concern is specifically regarding "Cases Not Subject to Review," "Refusal to Cooperate" and "Failure to Cooperate, " commonly referred to as "dropped cases."

The federal policy regarding the disposition of cases dropped from the QC sample applies to states with paper files, as well as to states without paper files. Every state, regardless of its system of eligibility determination, drops cases from the sample for the same reasons Tennessee drops cases. None of the dropped cases are used to calculate an error rate. If the QC reviewer is unable to complete the review for any number of valid reasons, it is inappropriate to show the case as being in error or as being correct.

The Quality Control reviewer examines eligibility in a particular month, not necessarily in the month of application. Therefore, no matter what documentation is or is not on file, all points of eligibility must be re-verified by the QC reviewer independent of the initial determination. We do not rely, nor have we ever relied, on the documentation of the county office provided at the time of the eligibility interview, whether it is paper or electronic.

Another federal/state requirement is the right of all program applicants/recipients to due process through a fair hearing. Fair hearings are held to review challenged case actions. Since the implementation of ACCENT, there has been no challenge of the use of an electronic file in eligibility determinations.

Rebuttal

While keeping copies of various documents to support eligibility determinations is not a guarantee that individuals are indeed eligible, it is a piece of evidence that provides some additional assurance that the correct determination was made. If that documentation is maintained, it would seem less likely that eligibility workers might enter unsupported information into the system. It would also allow those who might have cause to review eligibility determinations, such as supervisors, internal auditors, and external auditors, to have some additional assurance that the correct determination was made.

Not maintaining adequate documentation could make criminal prosecution of enrollees more difficult. For example, if an enrollee is believed to have fraudulently submitted information during the enrollment process, TennCare could provide evidence of critical documentation such as pay stubs or statements of medical expenses to assist in proving that the applicant intentionally misrepresented eligibility information.

Finally, our discussions with the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services have indicated that office believes documentation is necessary and required by Office of Management and Budget, Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*.

10. TennCare does not have a court-approved plan to redetermine or terminate the TennCare eligibility of SSI enrollees that become ineligible for SSI

Finding

As noted in a prior audit finding, TennCare does not redetermine or terminate the TennCare eligibility of Supplemental Security Income (SSI) enrollees that become ineligible for SSI. This is because TennCare does not have a court-approved plan which allows TennCare to make a new determination of the eligibility of these enrollees. According to 1200-13-12-.02(1)(c) of the *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare*, "The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) program. In Tennessee, SSI recipients are automatically eligible for Medicaid. All SSI recipients are therefore TennCare eligibles." However, when an individual enrolled in TennCare as an SSI enrollee is terminated from SSI, TennCare does not redetermine or terminate the enrollee's eligibility. Management concurred in part with the prior audit finding and stated,

> The State is prohibited by court order from disenrolling persons who have been enrolled in TennCare as SSI recipients at any time since November 1987, unless these persons die or move out of state and indicate a wish to be transferred to the Medicaid program in their new state. These individuals are carried on the TennCare rolls as Medicaid eligibles, which means that they have no copayment obligations. Until such time as the State can terminate the TennCare eligibility of former SSI enrollees, we believe it makes more sense to focus our reverification efforts on those enrollees who could actually be disenrolled from the program.

During the current audit TennCare management indicated that to comply with the *Cluster Daniels, et. al. vs. the Tennessee Department of Health and Environment, et. al.* court order, TennCare does not terminate SSI recipients unless the recipient dies, moves out of state and is receiving Medicaid in another state, or requests in writing to be disenrolled. However, the court order states,

> . . . defendants are hereby ENJOINED from terminating Medicaid benefits without making a de novo [a new] determination of Medicaid eligibility independent of a determination of SSI eligibility by the Social Security Administration. The Court further ENJOINS defendants to submit to the Court and to plaintiffs, within thirty (30) days of entry of this Order, the plan by which defendants have implemented de novo determination of Medicaid eligibility. . . .

Furthermore, the court has required that the Medicaid program must make a determination whether or not the recipient's termination from SSI was made in error.

Management stated that TennCare follows the direction of the Attorney General's office on how to comply with the court order. We requested information from the Attorney General's office on this matter and received a response dated October 17, 2001, which stated,

> There is no reason that the affected state agencies (Bureau of Medicaid/TennCare, Department of Human Services) cannot or should not proceed to attempt to comply with the district court's orders and injunction by devising a plan which would satisfy the requirements of those orders. (Under the terms of the Court's orders, the Court will have to approve any State plan to make de novo determinations of Medicaid eligibility independent of determinations of SSI eligibility by the Social Security Administration.) Furthermore, we understand that a number of efforts have been made over the years following entry of those orders to devise a plan which would satisfy the orders' requirements. The efforts have included extensive negotiations between counsel for plaintiffs, counsel for the federal defendants, the Attorney General's office and the Tennessee Department of Human Services (which makes, under law, the Medicaid eligibility determinations). Unfortunately, these efforts have been unsuccessful to date.

By not developing and implementing a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and to terminate ineligible enrollees, TennCare is allowing potentially ineligible enrollees to remain on TennCare until they die, move out of state and receive Medicaid in another state, or request in writing to be disenrolled.

Recommendation

The Director of TennCare should ensure that TennCare complies with all court orders and injunctions that relate to the eligibility of SSI enrollees. TennCare should develop and implement a court-approved plan that would allow TennCare to determine if terminated SSI recipients are still eligible for TennCare and terminate ineligible enrollees.

Management's Comment

We concur. The Director of TennCare should ensure that TennCare complies with all court orders and injunctions that relate to the eligibility of SSI enrollees.

The Director will ask the Attorney General to take action to bring this issue back before the court for final disposition. This request will be based, at least in part, upon the decision in Cureton v. Rudolph, in which the United States District Court for the Middle District of Tennessee, Nashville Division, held that the State is bound by disability decisions made by the Social Security Administration. Therefore, an enrollee is not entitled to a State hearing on an allegation of disability which has been declined or revoked by the SSA.

The AG will be asked to present this decision, coupled with assurances that eligibility review will be performed by the Department of Human Services to determine whether the individual qualifies for any other category of TennCare benefits (including the right to appeal if DHS determines that the individual is no longer eligible for any category of benefits) to the Court with a request to set aside or modify its November 13, 1987, Order. A positive finding by the Court could lift the injunction and permit the disenrollment, if appropriate, of those individuals who have been provided continuous Medicaid and TennCare benefits following termination of SSI.

11. TennCare should seek revisions to the TennCare waiver which would require specific medical conditions for eligibility

Finding

The Office of Health Services Audit, Investigations, and Program Integrity unit in the Department of Finance and Administration is charged with the internal audit function for the Bureau of TennCare. The office performed an audit of the TennCare Uninsurable Program within the Department of Finance and Administration, Bureau of TennCare, for the period January 1, 2000, through October 23, 2000. The issues noted in this finding were originally noted in the office's TennCare Uninsurable Program internal audit report dated May 24, 2001.

The current TennCare waiver population includes those determined to be uninsurable. To be eligible for TennCare as an uninsurable enrollee, TennCare, as specified by the TennCare waiver, requires only a letter of denial from the insurance agent. TennCare does not require medical verification to determine the uninsurable condition.

As a result of the design of the program, the program currently does not have medical criteria to indicate what conditions are considered uninsurable. Furthermore, this decision is made by the insurance companies and not by TennCare staff. Without establishing medical criteria to define what conditions qualify as uninsurable, TennCare is giving the insurance agent the authority to make this decision.

The audit completed by the Office of Health Services Audit, Investigations, and Program Integrity noted that "67 percent of the insurance agents surveyed issued a letter of denial based on sole representation of the applicant. No medical documentation was submitted to the agent to support the statement. Of the insurance agents surveyed, 87 percent of the applicants who received a denial letter from the insurance agent did not submit an application for medical/hospital insurance to the insurance company."

Also, according to the report, "There is a lack of verification of the information contained in the letter of denial from the insurance company or agent. We examined 176 uninsurable applications from all the areas that processed uninsurable applications. We noted two applications with the letter of denial that did not state medical reasons as the reason for denial of insurance. In addition, we noted two applications not dated by the applicant, and three applications not signed by the spouse. . . . Two applications had a letter of denial that was not dated. Three applications had letters of denial with computer generated signatures from the insurance agents."

The Bureau of TennCare's procedures for processing uninsurable applications state that the, "Current date on the denial letter cannot be over one (1) year old and the letter must be dated. The letter must be on insurance company letterhead stationery. If not on letterhead stationery, call insurance company and verify. . . . Denial must be for health or medical reasons only." According to TennCare personnel, the denial letter must be signed by the insurance agent, and computer-generated signatures are not accepted. In addition, the TennCare application requires the signature and date of the applicant's spouse if the applicant is married.

Recommendation

The Director should seek revisions to the TennCare waiver that would require better proof of uninsurability and, thereby, reduce the likelihood of individuals improperly obtaining TennCare coverage. The waiver could specify what medical conditions are considered uninsurable and could require evidence of that condition be obtained from a medical professional. The Director should ensure that all applications are dated and signed by the spouse and that denial letters that are signed by the insurance company electronically are not accepted.

Management's Comment

We do not concur. The finding addresses policy issues that are outside the scope of the current design of the TennCare Program. The TennCare waiver, which was approved by the federal government in 1993, establishes requirements for uninsurable applicants. Applicants demonstrate they are uninsurable by providing a letter from a health insurance company denying coverage for insurance because of a health reason. There have never been requirements that applicants submit medical documentation or that TennCare establish medical criteria for conditions that would be considered uninsurable. It seems inappropriate, therefore, to take a finding in an area where TennCare is acting in accordance with its approved waiver.

TennCare, in addition to accepting uninsurable letters in accordance with the rules, now accepts medical documentation from health care providers in order to prove uninsurability. This change of policy results from the federal suit Hamby, et al. v. Menke, et al. U.S. Dist.Ct. No. 3:98-1023 (M.D. Tenn), April 13, 2001. The Bureau is not budgeted for health insurance underwriters, but in compliance with due process safeguards, such proof is admitted before administrative judges and hearing officers in fair hearings, to enable the presiding officer to weigh the proof as to uninsurability.

Modifications to the TennCare waiver were submitted to the U. S. Department of Health and Human Services on February 12, 2002. The proposed modifications would change the current process for uninsurable applicants. Rather than having an uninsurable category, a category of eligibility referred to as "medically eligible" would be established. Eligibility for these applicants would be based on a single underwriting standard. If approved, this change will be effected in the rules, and the rule of the uninsurable letter from an insurance company will be obsolete.

Meanwhile the Bureau, under guidance of in-house counsel, is examining the insurance denial letter process and the policies related to it. The Office of General Counsel Resolution Unit contacts agents, agencies and insurers, where appropriate, to document underwriting practices, verify information and review the denial letter process in those cases for fair hearing, where the denial letter has been deemed inadequate proof of uninsurability by the Bureau. This check adds a layer of scrutiny to discover uninsurability which meets the rule in otherwise questionable cases.

We disagree with comments in the internal audit report regarding insurance industry practice in the verification of applications. It is common practice among large insurers to take "pre-applications," by asking simple health questions. That 'asking' may be over the phone, in writing, or over the Internet. These agents are 'field underwriters.' That is they are trained and authorized to review applications as well as pre-app information and review it against basic underwriting guidelines. Questionable areas and more complex decisions are handled by home office underwriters. The determinations as to insurability are properly overseen by home office underwriters, and the determinations by the field are no less binding and valid than if rendered by the senior home office underwriter.

Further the General Assembly has sought to curb practices of insurance underwriting where field agents might wish to select against TennCare by culling out more at-risk individuals in insurance programs, and to declare them uninsurable so as to render them eligible for TennCare. See, e.g. *Tenn. Code Ann*. §56-6-163. PIU is investigating agents and agencies who may be violating the above statute as well as committing fraud against TennCare. Under the Agreed Order PIU has been and continues to investigate those with access to insurance. Those identified are terminated and provided due process.

Rebuttal

This finding was not to show TennCare's failure to comply with current rules or regulations, except in the cases noted. We are required by OMB Circular A-133, Section 510(a)(1), to report deficiencies in internal control over major federal programs. It was our intent with this finding to show that design of the current waiver is not based upon specific medical criteria. As stated in the finding, in the survey conducted, 67% of the insurance agents surveyed issued a letter of denial based on sole representation of the applicant. Since a majority of insurance agents issue denial letters based upon the representation of the applicant and TennCare does not have specific medical eligibility requirements, the risk is increased that those enrolled in the program are not truly uninsurable.

Although management do not concur with the finding, they indicate that a modification to the waiver was submitted on February 12, 2002, which will change the waiver to include those who are "medically eligibile."

Management did not address the part of the recommendation concerning applications not being signed and dated and denial letters that are electronically signed.

12. Internal control over TennCare eligibility is not adequate

Finding

As noted in the six prior audits of the Bureau of TennCare, internal control over TennCare eligibility is not adequate. Management concurred in part with the prior audit finding, as discussed throughout this finding. However, problems still exist.

For the uninsured and uninsurable population, which makes up approximately 43% of all TennCare enrollees, responsibility for initial eligibility determination is divided between the county health offices in the Department of Health and the Member Services Unit in the Bureau of TennCare. For the Medicaid population, the Department of Human Services has the responsibility for eligibility determinations. The Department of Children's Services is responsible for eligibility determinations of children in state custody.

Inadequate Policies and Procedures

As noted in the prior two audits, TennCare has not provided the county health offices with a uniform, written policies and procedures manual. Management concurred in part with the prior audit finding and stated that "a companion document [policies and procedures manual] is being developed for health departments." According to the Director of Member Services, as of September 5, 2001, the manual was still in the draft stage. Since the county health offices are involved in the eligibility process for the uninsured and uninsurable population, without a

uniform written policies and procedures manual for the county health offices, TennCare cannot ensure that TennCare recipients are appropriately and consistently determined to be eligible for TennCare.

Inadequate Staff to Verify Information on Applications

Management stated in response to the prior audit finding that "in order to resolve these issues, we are organizing a new Member Services Unit which will handle all member communications, as well as oversight of eligibility, enrollment, reverification, and administrative appeals." Although a new Member Services Unit has been organized, the unit within Member Services that reviews the uninsurable, uninsurable with limited benefits, and uninsured with COBRA termination applications is still understaffed. The unit receives approximately 1,000 applications weekly. During the audit period, there were two individuals who initially reviewed the applications to verify the information for completeness and accuracy. As a result of the unit being understaffed, not all the information on the applications (e.g., income, access to insurance, and citizenship status) is verified for accuracy. Not verifying information on these applications increases the risk that ineligible recipients are enrolled.

Recipients Found on TennCare Twice

Using computer-assisted audit techniques to search the TennCare recipient eligibility history file located on the TennCare Management Information System (TCMIS), a listing of 1,018 recipient records with duplicate social security numbers was compiled. A sample of 60 sets of recipient records with duplicate social security numbers representing 120 of the 1,018 recipient records was tested to determine if overlapping capitation or fee-for-service payments were made during the fiscal year ended June 30, 2001. Testwork revealed that for 9 of 60 sets of recipient records with duplicate social security numbers tested (15%), overlapping capitation payments were made. Follow-up with management regarding these nine pairs of recipient records revealed that these nine individuals were on TennCare twice for all or part of the dates of services that were paid for during the audit period.

TennCare's capitation payment amounts for recipients are based upon the recipients' managed care organization (MCO), age, eligibility classification, and the region of the state. In some cases, when overlapping payments were found, different capitation rates were paid for each recipient in a set. It could not be determined which recipient record contained the appropriate payment and which recipient record contained the inappropriate payment. As a result, we had two different amounts in each set of recipient records that could be unallowable.

In recipient records with the higher amount of overlapping capitation payments, the errors totaled $6,752. The federal questioned costs for these recipient records totaled $4,295, and the remaining $2,457 is state matching funds. In recipient records with the lower amount of overlapping capitation payments, the errors totaled $4,031. The federal questioned costs for these recipient records totaled $2,565, and the remaining $1,466 is state matching funds. We believe likely questioned costs exceed $10,000.

Because adequate controls are not in place to ensure that enrollees with the same social security number are only enrolled in TennCare one time, TennCare cannot ensure that it is not making duplicate capitation or fee-for-service payments for the same person.

No Verification of Applications

Management stated in response to the prior audit finding, "We believe that the accuracy of eligibility determinations will be improved with our new Member Services Unit and proposed rules and policies." However, the Bureau still does not verify information contained on applications for individuals losing Medicaid eligibility. According to 1200-13-12-.02(5)(a) of the *Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare*,

> Persons losing Medicaid eligibility for TennCare who have no access to insurance may remain in TennCare if they are determined to meet the non-Medicaid TennCare eligibility criteria.

These applications are entered on TCMIS and processed without verification of information contained on the application. Without verifying the information on the applications, the Bureau of TennCare cannot ensure that the applicant meets non-Medicaid TennCare eligibility criteria. In addition, not verifying the information on the applications can result in inaccurate premium amounts based upon the unverified and possibly inaccurate income amounts reported by the recipient.

Enrollees With Out-of-State and Post Office Box Addresses Discovered

As noted in the prior audit, TennCare made payments on behalf of out-of-state residents. Management concurred in part and stated that the "definition of Tennessee residency is a part of the on-going lawsuit negotiation. Once resolved, the definition will be used by the Bureau." According to management at TennCare, for more than half of fiscal year ended June 30, 2001, enrollees who had moved out of state could not be disenrolled because of the Temporary Restraining Order. (See finding 8 for more information regarding the restraining order.) In February 2001, the federal court approved policies and procedures for disenrollment of enrollees who have moved out of state. These procedures were not placed in operation during our audit period; however, they were implemented in July 2001.

Using computer-assisted audit techniques to search the TennCare recipient file located on TCMIS, we found 19,959 enrollees who have a non-Tennessee address. Some of the enrollees have addresses in other countries. The total amount paid on behalf of these enrollees was $48,620,701. One of the requirements of TennCare eligibility listed in the *Rules of the Tennessee Department of Finance and Administration*, 1200-13-12-.02(3)(b)(2), states that the non-Medicaid eligible applicant "must be a Tennessee resident." In addition, the *Rules of the Tennessee Department of Human Services*, 1240-3-3-.02(6), states that to be a Medicaid-eligible enrollee, "an individual must be a resident of the State of Tennessee, as defined by federal regulations at 42 CFR 435.403."

TennCare has established a policy for terminating enrollees with an out-of-state address that defines residency. The *TennCare Eligibility Policies and Procedures Manual*, Policy #AA-015, states, "State of residence is defined as the state where the individual has established a residence with the intention to remain there permanently or for an indefinite period of time." However, TennCare did not perform procedures during the audit period to determine which out-of-state addresses are appropriate. Some portion of the 19,959 enrollees may be appropriately considered residents of Tennessee. However, because TennCare has not determined which out-of-state addresses are appropriate, TennCare cannot provide any assurance that these individuals are eligible. Therefore, of the $48,620,701 paid, $30,931,274 is considered federal questioned costs. The remaining $17,689,427 is state matching funds.

In addition, using computer-assisted auditing techniques, we found 130,767 enrollees who have P.O. boxes listed as their address. Allowing enrollees to use P.O. box addresses makes it very difficult to ensure compliance with the rules cited earlier that require residency in the State of Tennessee. The TennCare application requires enrollees to include their legal address (home address). The application states, "Do NOT list a P. O. Box as your home address." The application also includes a line for the enrollee's mailing address, which could be a P. O. Box. However, management stated that in certain cases, TennCare believed that only P.O. Box addresses were necessary. Some of these cases include, for example, homeless individuals, individuals who reside in an area of Tennessee where the post office will not deliver to the street address (i.e., in a rural area), individuals who require their address to remain a secret in order to protect themselves from physical harm, and enrollees in state custody or in a mental institution. Testwork revealed that TennCare has not established a written policy that describes the instances where the use of only P.O. boxes would be allowable. Furthermore, TennCare has not developed a way of identifying the individuals who would be in these categories. The amount paid on behalf of these individuals was over $465 million.

Pseudo Social Security Numbers Again Discovered

As noted in the four previous audits, when computer-assisted audit techniques were used to search TCMIS, testwork revealed that 86 TennCare participants had "pseudo social security numbers" that began with "888" or have all zeros in one field. According to TennCare personnel, some applicants who do not have their social security cards and/or newborns who have not yet been issued social security numbers are assigned these "pseudo" numbers.

Testwork revealed that 76 of 86 individuals (88%) found with "pseudo" social security numbers had not had a correct social security number entered on TCMIS, although they were enrolled more than one year. The Bureau does not have a time limit for the use of pseudo social security numbers. Some of these TennCare participants had been enrolled in the Medicaid program as early as 1986. Also, while it is not always possible to obtain social security information for newborns (0-3 months), auditors noted that several individuals with pseudo social security numbers were over one year old. The total amount improperly paid for the errors noted above was $72,711. Federal questioned costs totaled $46,257. The remaining $26,454 was state matching funds.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910, the state agency must require, as a condition of eligibility, that those requesting services (including children) provide social security numbers. Additionally, Section 3(g) of the same section states that "the agency must verify each SSN [social security number] of each applicant and recipient with SSA [Social Security Administration], as prescribed by the Commissioner, to ensure that each SSN furnished was issued to that individual, and to determine whether any others were issued."

Ineligible Enrollees Discovered

A sample of the Medicaid population, excluding Supplemental Security Income (SSI) enrollees, was tested to determine if the enrollees were eligible for Medicaid on the date of service, based solely upon the information in the Automated Client Certification and Eligibility Network (ACCENT). Testwork revealed that TennCare did not ensure that the Department of Human Services maintained adequate documentation of the information entered into ACCENT. See finding 9 for further details on this matter. Medicaid enrollees are enrolled through the Department of Human Services using ACCENT. TennCare receives daily eligibility data files from ACCENT, which update information in TCMIS. The Bureau of TennCare pays the MCOs and behavioral health organizations (BHOs) a monthly capitation payment to provide services to these enrollees. For the fiscal year ended June 30, 2001, the Bureau paid capitation payments totaling over $2.5 billion to MCOs and over $381 million to BHOs for TennCare enrollees. Of the 61 capitation payments for Medicaid enrollees tested, testwork revealed 13 enrollees (21%) were not eligible for Medicaid on the date of service, based solely upon the information in ACCENT. Of the 13 ineligible enrollees, 11 enrollees were no longer eligible for Medicaid according to ACCENT, one enrollee's medical expense was not supported in ACCENT, and one enrollee did not have a valid social security number.

For 8 of the 11 enrollees, Medicaid ended per ACCENT between March of 1994 and February of 2000. However, TennCare did not close their Medicaid eligibility on TCMIS, which allowed them to continue receiving Medicaid services. According to TennCare personnel, individuals losing Medicaid eligibility are mailed an application to complete and return to apply for TennCare as an uninsured or uninsurable enrollee. If the application is returned with incomplete information, it is placed on hold. TennCare has allowed enrollees with applications on hold to remain on Medicaid instead of following up on these applications. For 2 of the 11 enrollees, Medicaid eligibility ended on ACCENT after 18 months of "Transitional Medicaid." In Tennessee, Families First eligibility automatically qualifies an individual for Medicaid. According to the Families First Policy and Procedure Manual, "Transitional Medicaid" is Medicaid eligibility that is extended for 18 months after an individual loses Families First eligibility. However, TennCare did not close their Medicaid eligibility on TCMIS until 24 months after the end of Families First eligibility. Per discussion with TennCare personnel, TennCare gives eligibility for these individuals in segments of 12 months only. Management stated there was a section in the TennCare waiver that allows the granting of multiple 12-month segments for these enrollees. It appears that the TennCare waiver grants eligibility for only one year for "medically needy" enrollees if they are eligible for any month of a calendar year. The enrollees in question were classified as "categorically needy," not as "medically needy".

Additionally, one of the 11 enrollees' Medicaid eligibility ended on ACCENT in November of 2000 because the enrollee moved out of state. However, TennCare did not close this person's Medicaid eligibility on TCMIS until August 2001, at the end of a 12-month segment. This enrollee is also classified as "categorically needy."

The Medicaid population, excluding SSI enrollees, makes up approximately 53% of the TennCare population. The total amount of capitation improperly paid for all the errors noted above was $1,271, out of a total of $6,320 tested. The total amount of errors not already questioned in other sections of this finding is $1,157. Federal questioned costs totaled $736. The remaining $421 was state matching funds. We believe likely questioned costs exceed $10,000.

Because TennCare has not ensured that only Medicaid-eligible individuals are enrolled in TennCare as a Medicaid enrollee, ineligible enrollees could be inappropriately enrolled in other programs. For example, according to the *Code of Federal Regulations*, Title 7, Part 246, Section 7 (d)(2)(vi)(A), Medicaid enrollees are automatically income-eligible for the Department of Health's special supplemental nutrition program for women, infants, and children (WIC).

Recommendation

The Director of TennCare should promptly develop and implement an adequate, uniform, written policy and procedures manual for the county health offices to ensure that the eligibility status of TennCare recipients is determined properly, consistently, and timely. The Director should ensure that adequate staff is assigned to verify information on uninsurable, uninsurable with limited benefits, and uninsured with COBRA termination applications. The Director should ensure that enrollees are not enrolled on TennCare more than once. In addition, the Director should ensure that the information contained on applications for individuals losing Medicaid eligibility is verified.

The Director of TennCare should also ensure that the court-approved policies and procedures for disenrollment of enrollees who have moved out of state are implemented. The Director should ensure that the Bureau develops a written policy that describes the situations where use of a P.O. box would be allowable. In addition, the Director should ensure that valid social security numbers are obtained for all individuals in a timely manner. All applications that are currently on hold should be followed up on and resolved. The Director should ensure that only eligible Medicaid enrollees are receiving TennCare. Ineligible Medicaid enrollees should be removed from the program.

Management's Comment

Inadequate Policies and Procedures

We concur. However, we are pleased to report that a desk reference, which includes guidance and uniform policies and procedures for workers in the 95 county health department

offices, will be distributed by the end of February 2002. TennCare's Division of Member Services worked with the Department of Health in the development of the *Health Department Desk Reference* and an accompanying training guide. In addition, two training sessions were held in October and December 2001 with Department of Health, Health Services Administration Help Desk staff in order that they could begin the process of training their staff.

Inadequate Staff to Verify Information on Applications

We concur. Members Services reorganized resources to assure that all services related to members were under one TennCare Division. However, staffing of the uninsurable unit has not increased. The unit is still not staffed to verify all information on all TennCare applications. Under the modifications to the TennCare waiver, submitted to U. S. Department of Health and Human Services in February 2002, the Department of Human Services would be the single point of entry for all TennCare applications. This process will include a face-to-face interview with verification of critical eligibility components. If approved, the modified waiver would become effective January 1, 2003, with eligibility determinations to begin July 1, 2002, at the county Department of Human Services offices.

Recipients Found on TennCare Twice

We do not concur. TennCare has a process in place to ensure that duplicate records do not occur for the same individual in the TCMIS. TennCare executes a weekly process which identifies potential records that need to be merged together as a single record. Records that meet these criteria must match on specific data elements. The monthly capitation payment cycle will recover any duplicate capitation payments for up to twelve months of reconciliation. Suspect records from the weekly process are reviewed manually and corrected if needed. Information Systems has documented procedures for this process. TennCare Information Systems management will review the auditors' samples as a follow-up to this finding.

No Verification of Applications

We concur. As stated previously in the response to Inadequate Staff to Verify Information on Applications, the Division of Member Services currently does not have the staffing capability to verify all the information on every application that it is received. It should also be pointed out that in the original TennCare waiver, the application process for the demonstration eligible enrollees was designed to be as simple as possible. We did not have staff devoted to verification of information submitted, although we did put in place various data matches to identify persons who might have access to insurance. The new waiver design, which upon approval is intended to go into effect in July, requires that persons applying for the demonstration population, including those who are exiting the Medicaid program, go into Department of Human Services offices to have all information checked in a face-to-face interview process. This process will be more rigorous than the process that is currently in place and will resolve this finding, we believe.

Enrollees With Out-of-State and Post Office Box Addresses Discovered

We concur. Termination of out-of-state enrollees was held up because of the Temporary Restraining Order. Since that time, the Bureau has worked to identify and disenroll out-of-state

enrollees when possible. In accordance with the Settlement Agreement to the Agreed Order, the enrollees with out-of-State addresses have been identified and contacted by the Program Integrity Unit (PIU) of the Office of Health Services. The PIU has opened over 6,000 cases of enrollees with out-of-state addresses. Approximately one-third of these cases has been closed, resulting in 1,737 recommended terminations. As of February 2002, 748 enrollees elected voluntary termination. Notices are currently being sent to enrollees with verified out-of-state addresses, who did not elect to voluntarily terminate. These enrollees will be afforded all due process appeal rights. In some cases, enrollees have disputed living out-of-state. The PIU will examine the proof presented by these enrollees and determine whether to recommend termination. Where adverse decisions result, enrollees will be given proper notice of termination and due process appeal rights. Cases will be closed where the affected individuals establish proof of their Tennessee residence. Addresses for some enrollees cannot be confirmed. The out-of-state address of record has been cross-checked with the MCOs, but no confirmation has been received in the Bureau's attempt to contact these individuals. TennCare is reviewing with counsel how to proceed so as to (1) terminate individuals who are not eligible; and (2) afford them their due process rights. In addition, printing and distribution of the desk reference to all local Department of Health offices will be completed in February 2002.

Pseudo Social Security Numbers Again Discovered

We concur. There are pseudo social security numbers in the TCMIS and the Bureau is working on a means of validating and correcting them through the Social Security Administration (SSA). The TCMIS assignment of pseudo social security numbers occurs for newborns to the system through the uninsured/uninsurable process. Currently, any adds to the TCMIS will also assign pseudo social security numbers for any record added to the system received from eligibility determination by external entities such as the Department of Human Services (DHS) and the Social Security Administration (SSA).

Ineligible Enrollees Discovered

We do not concur that individuals eligible under Medicaid categories in the TCMIS and not eligible in ACCENT represent ineligible TennCare enrollees. As stated in the audit finding, existing business rules allow certain categories of eligibles to be extended for up to 12 months of eligibility within the TCMIS. We concur that Medicaid enrollees could remain eligible beyond the twelve month extended end date as a result of pended/incomplete applications. TennCare generates notices to all Medicaid enrollees 30 days in advance of reaching their TCMIS end date. If an application is entered into ACCENT or the TCMIS within the window allowed, the end date is opened until the application is completed. TennCare Information Systems has worked closely with the Department of Human Services to ensure these pended applications are reported accurately to TennCare, and TennCare reviews any incomplete/pended uninsured/uninsurable applications.

Beginning in November 2001 TennCare is identifying the population who have been extended for greater than 12 months of eligibility with aged/pended or incomplete applications, loading end dates to those records and re-sending the 30 day advanced termination notice.

Rebuttal

Recipients Found on TennCare Twice

As stated in the audit finding, we found duplicate payments for individuals who were enrolled on TennCare twice. Because our audit work found these duplicate payments, it is clear that the procedures described by management were not effective and need improvement.

Ineligible Enrollees Discovered

As noted in the finding, we found 13 enrollees who were not eligible for Medicaid on the dates of service. Although management does not concur, it has not provided any documentation to support the eligibility of those enrollees in question.

Furthermore, there is no provision in the rules or written policies that allows individuals who submit incomplete applications to remain eligible for program services indefinitely. As stated in the audit finding, one enrollee's application has been on "hold" since March of 1994.

13. TennCare made payments on behalf of full-time state employees, resulting in federal questioned costs of $476,506 and an additional cost to the state of $272,511

Finding

As noted in the prior audit, TennCare paid capitation payments on behalf of full-time state employees who are classified as uninsured or uninsurable in the TennCare Management Information System (TCMIS). Management concurred with the prior audit finding and stated that "TennCare currently is operating under a temporary restraining order that does not allow us to terminate any uninsured/uninsurable member for any reason other than a voluntary termination per the member's request or by death." (See finding 8 for more information regarding the restraining order.) However, in February 2001, the court approved policies and procedures for disenrollment of enrollees who have confirmed access to other insurance. Although no disenrollment of state employees occurred during the year ending June 30, 2001, procedures were placed in operation to identify these enrollees. According to the Department of Finance and Administration, Division of Insurance and Administration personnel, all full-time state employees have access to health insurance at the time of hire or when the employee reaches full-time status.

According to *Rules of the Tennessee Department of Finance and Administration*, 1200-13-12-.02 (3)(b)(5), to be eligible for TennCare as an uninsured or uninsurable, an applicant "must not be eligible for participation in an employer sponsored health insurance plan, either directly or indirectly through a family member and must not have been eligible for such coverage as of March 1, 1993 (effective October 1, 1994 as of July 1, 1994). . . ." Also, rule 1200-13-12-.02 (5)(b)(1) states that TennCare shall cease when "the enrollee becomes eligible for participation in an employer sponsored health plan, either directly or indirectly through a family

member." State employees were not disenrolled during the year ending June 30, 2001; therefore, TennCare was not in compliance with these rules.

Using computer-assisted audit techniques to search TennCare's paid claim records, testwork revealed that 542 uninsured and uninsurable TennCare participants were also full-time employees who were eligible for insurance through their employment with the State of Tennessee. Of the 542 enrollees, 454 recipients have had a deduction for state insurance through state payroll at least once in the past two years, and 88 recipients have not. All these employees have access to health insurance and are not eligible for the TennCare program according to rules for eligibility.

The total amount of capitation payments paid for the errors noted above was $749,017. Federal questioned costs totaled $476,506. The remaining $272,511 was state matching funds.

Recommendation

The Director of TennCare should continue to ensure that any court-approved procedures are followed. Bureau management should ensure that full-time employees of the State of Tennessee are removed from the TennCare rolls.

Management's Comment

We concur. A process was put in place in May 2001 to ensure that full-time employees of the State of Tennessee are removed from the TennCare rolls. The Department of Finance and Administration, Division of Insurance, sends a database from the Tennessee Insurance System to TennCare once a quarter of all new state employees. That database is then forwarded to TennCare Information Systems to complete an electronic match against the TennCare rolls. TCMIS sends Program Integrity a list of perfect and imperfect matches.

For perfect matches, an employer verification letter is sent to the Department of Finance and Administration, Division of Insurance to complete. Once this verification letter is returned to Program Integrity, the TennCare eligibility screens are reviewed to determine the state employee's (and family members, when applicable) TennCare enrollment type (Waiver, DHS, SSI) & the income level when there are children on the TennCare case. Referrals are made to Administrative Appeals for termination and to TCMIS to add TPL, if this is not already reported. However no referral is made to Administrative Appeals recommending termination for Medicaid enrollees or for children who are below poverty guidelines, with access to insurance only; this group of enrollees cannot be terminated under current rules and regulations.

TCMIS is in the development stage to automate this comparison of data systems, and thereby expedite the identification of all state employees with insurance and access to insurance. Once TIS verifies data, the Program Integrity Unit will then recommend appropriate action, such

as referring to Appeals for termination, referring to TCMIS to add Third Party Liability insurance or access, or to add and/or update income.

When an imperfect match is received from TennCare IS, Program Integrity investigates to determine if there is an unreported marriage or divorce, or if the Social Security number on one of the databases is incorrect. If the investigation does not validate this information, the case is closed and no referral is made to Administrative Appeals for termination. When an investigation validates that the identity of the TennCare enrollee is the same as the state employee, the case is worked the same as the perfect matches. Program Integrity recommended termination of 672 state employees, and forwarded documentation to add health insurance coverage for 633 cases during the months of May and June 2001. However, due process prevented these state employees from being terminated until fiscal year 2001-2002.

However, we do not concur with the questioned costs. We terminated these enrollees when permitted by the court and other procedures were followed ensuring these enrollees were not eligible and received due process.

Rebuttal

OMB Circular A-133 defines a questioned cost as a cost which "resulted from a violation or possible violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of Federal funds, including funds used to match Federal funds." TennCare should not pass on costs to the federal government when it has failed to establish adequate due process procedures resulting in a court order. If TennCare had adequate due process procedures in place, the court would not have issued the court order. See finding 8 for further details regarding this matter.

14. Controls over the eligibility of state-only enrollees need improvement

Finding

As noted in the prior audit, controls over the eligibility of state-only enrollees need improvement. As a part of the TennCare Partners Program, TennCare provides behavioral health coverage to individuals who would not be eligible for the TennCare program under the Medicaid rules. Individuals classified as state-only enrollees include non-United States citizens, prisoners, those who have mismatched social security numbers, and non-Tennessee residents. The state-only enrollees' coverage is funded totally with state funds. Currently there are 1,266 individuals who are classified as state-only enrollees.

Management concurred with the prior audit finding and stated,

> Enrollment and disenrollment of State-only enrollees is the responsibility of the Department of Mental Health and Developmental Disabilities, as documented in a

Memorandum of Understanding dated January 31, 2000. We will direct DMHDD to complete the requested procedures and assure compliance with this finding.

However, the Bureau of TennCare did not assure that state-only enrollees were reverified and ineligible enrollees disenrolled. Management at the Department of Mental Health and Developmental Disabilities (DMHDD) stated that enrollment for the state-only category ended June 30, 2000, and that TennCare has not given DMHDD the computer access required to disenroll state-only enrollees.

Neither DMHDD nor the Bureau of TennCare monitored or reverified the eligibility of state-only enrollees. There were also no procedures to reverify the eligibility of state-only enrollees. The state-only category was designed to be a temporary situation for the enrollees; however, because there are no monitoring and reverification procedures, these enrollees have remained on the TennCare Partners Program without any redetermination of their eligibility since 1998.

According to the *Rules of the Tennessee Department of Finance and Administration* 1200-13-12-.02 (8)(b)(2), to be eligible as a state-only enrollee, the enrollee must have a family income that does not exceed 100% of the federal poverty level. However, testwork revealed that 89 of 1,266 state-only enrollees (7.03%) had an income recorded in the TennCare Management Information System (TCMIS) that exceeded the poverty-level income standard. Since there are no redetermination procedures, these individuals have remained in the program. The $7,186.15 associated with these 89 individuals was paid with all state dollars. As a result, there are no federal questioned costs associated with this condition.

Recommendation

The Director of TennCare should develop and implement monitoring procedures to ensure that individuals classified as state-only enrollees remain eligible for the program. The Director should determine which enrollees are not eligible and remove those enrollees from the program. Otherwise, the Director of TennCare should ensure DMHDD performs monitoring procedures to ensure that state-only enrollees remain eligible and give DMHDD the computer access required to remove ineligible individuals from the program.

Management's Comment

We concur in part. The main responsibility for the eligibility of these enrollees is the DMHDD, who determines the eligibility for the state only enrollees in the Partners program. Additionally, the contract for the Partners program is between that department and the behavioral health organization. However, we do agree that procedures over this area need improvement.

We have reviewed the records and found that there are approximately 1200 members in this category, and not all of them are getting TennCare services. Certain policies and procedures were revised by DMHDD regarding certified uninsurables, judicials and state onlys. These

policies and procedures were submitted to and accepted by the federal court. One of the provisions stated that DMHDD would review individuals enrolled as "state onlys" every 6 months to determine if they were still receiving services and if they were still eligible as state onlys. To further address this issue DMHDD drafted changes to the TennCare rules regarding the State Only category. They are currently in the process of rule promulgation. When these rules are promulgated, we essentially can begin termination of the individuals noted.

Rebuttal

Management fully concurred with this audit finding last year. Since these costs flow from TennCare, the Bureau is ultimately responsible for seeing that eligibility is appropriately determined, redetermined, and monitored.

15. TennCare incorrectly reimbursed the Department of Children's Services for services that were unallowable or not performed, resulting in federal questioned costs of $803,576

Finding

As noted in the prior two audits, TennCare has paid the Department of Children's Services (Children's Services) for services that were unallowable or not performed. In accordance with its agreement with TennCare, Children's Services contracts separately with various practitioners and entities (service providers) to provide Medicaid services not covered by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) that are also under contract with TennCare. During the year ended June 30, 2001, TennCare paid approximately $122 million in fee-for-service reimbursement claims to Children's Services.

The previous audit finding addressed three specific types of unallowable payments made by TennCare to the Department of Children's Services that have not been corrected in the current year:

- payments for incarcerated youth,
- payments for children on leave status, and
- payments for services provided to children under three years.

Overall, testwork revealed that TennCare still did not have critical edits in place to detect and prevent DCS from billing for unallowable services. TennCare still made payments to DCS for services for incarcerated youth, children on leave status, and children under three years.

In a letter of correspondence from the U.S. Department of Health and Human Services (HHS) to the Commissioner of the Department of Finance and Administration (F&A) regarding

the Single Audit of the State of Tennessee for the period July 1, 1998, through June 30, 1999, HHS stated:

> This is a material instance of noncompliance and a material weakness. We recommend procedures be implemented to ensure Federal funds are not used to pay for (1) health care costs of children who are in youth development or detention centers, . . . on runaway status, . . . (2) behavioral health services for children under the age of three . . .
>
> Testwork revealed the following deficiencies:

Payments for Incarcerated Youth

Since 1997 TennCare has not identified incarcerated youth enrolled in the program and has paid for the health care costs of youth in the state's youth development centers and detention centers. Management concurred in part with the prior audit finding and stated, "We will request that [the Department of Finance and Administration] F&A Office of Program Accountability Review (PAR) strengthen its efforts to better identify these payments." Although PAR did strengthen its efforts to identify instances of incarcerated youth, payments were still made on behalf of children who were incarcerated.

Under federal regulations (*Code of Federal Regulations*, Title 42, Part 435, Sections 1008 and 1009), delinquent children who are placed in correctional facilities operated primarily to detain children who have been found delinquent are considered to be inmates of a public institution and thus are not eligible for Medicaid (TennCare) benefits.

Although TennCare's management has entered into a Memorandum of Understanding (MOU) with F&A Division of Resource Development and Support (RDS) to examine this area, TennCare still does not have adequate controls and procedures in place to prevent these types of payments.

Using computer-assisted audit techniques (CAATs), our search of TennCare's paid claims records revealed that TennCare made payments totaling $941,295 for the year ended June 30, 2001, for juveniles in the youth development centers and detention centers. Of this amount, $686,415 was paid to MCOs; and $254,880, to Children's Services. Federal questioned costs totaled $598,829. The remaining $342,466 was state matching funds.

The payments to the MCOs were monthly capitation payments—payments to managed care organizations to cover TennCare enrollees in their plans. Since the Bureau was not aware of the ineligible status of the children in the youth development and detention centers, TennCare incorrectly made capitation payments to the MCOs on their behalf. As a result, TennCare is making payments on behalf of these individuals to the MCOs who incur no costs for providing services.

Payments for Children on Leave Status

TennCare has paid for enhanced behavioral health services for children who are in the state's custody but are on runaway status or placed in a medical hospital. No services were performed for these children because they have run away from the service providers or have been placed in a medical hospital. Management also concurred with the portion of the prior audit finding related to payments for children on leave status and stated that

> TennCare has instructed DCS not to bill TennCare for services not provided to children on leave status. TennCare is developing a DCS Policies and Procedures Manual and will confirm this understanding in that manual. In addition, TennCare will request that F&A PAR strengthen its efforts to assure that inappropriate payments are better detected in the future.

Testwork revealed that TennCare did develop DCS policies and procedures; however, these were not placed in operation during the audit period. In addition, TennCare did make efforts to ensure F&A PAR strengthened its efforts to detect these types of payments. However, the problems with this area continue. According to Office of Management and Budget (OMB) Circular A-133, to be allowable, Medicaid costs for services must be for an allowable service that was actually provided. *Code of Federal Regulations*, Title 42, Part 1003, Section 102, prohibits billing for services not rendered.

It is the responsibility of Children's Services to notify TennCare when children run away from service providers or are hospitalized in a medical hospital. Auditor inquiry revealed that Children's Services does not notify TennCare when children are on runaway status or are placed in a medical hospital. TennCare relies upon Children's Services not to bill TennCare when it is determined the child has run away or been placed in a medical hospital. The Children's Services' provider policy manual allows service providers to bill Children's Services for up to 10 days for children on runaway status, but Children's Services cannot bill TennCare for those days. The Children's Services' provider policy manual also allows service providers to bill Children's Services for seven days if the provider plans to take the child back after hospitalization. If the provider has written approval from the Children's Services Regional Administrator, the provider may bill for up to 21 days while the child is in the hospital, but Children's Services cannot bill TennCare for any hospital leave days. In spite of repeat audit findings the Bureau still has no routine procedures, such as data matching, to check for such an eventuality. Therefore, it was again unaware Children's Services was reimbursed for particular treatment costs that were not incurred by the service providers. However, based on the prior findings, TennCare was aware of the possibility of such costs and should have taken appropriate action to identify such situations.

Using CAATs, we performed a data match comparing TennCare's payment data to runaway records from Tennessee Kids Information Delivery System (TNKIDS). The results of the data match indicated that for the year ended June 30, 2001, TennCare had improperly paid $266,670 to Children's Services for children on runaway status. Federal questioned costs totaled $169,649. The remaining $97,021 was state matching funds.

In addition, using CAATs, we performed a data match comparing TennCare's payment data to medical records from the MCOs. The results of the data match indicated that for the year ended June 30, 2001, TennCare had improperly paid $42,151 to Children's Services for children while they were in hospitals. Federal questioned costs totaled $26,815. The remaining $15,336 was state matching funds.

Payments for Services Provided to Children Under Three Years

Despite HHS' recommendation discussed above, and audit findings repeated for the last two years, TennCare failed to take corrective action and again paid Children's Services for behavioral health services provided to children under the age of three. As in previous years, using CAATs, a search of TennCare's paid claims records revealed that for the year ended June 30, 2001, TennCare improperly paid 1,946 claims totaling $1,142,312 for children under the age of three. An analysis of 292 claims totaling $170,739 revealed that 232 were properly voided and reimbursed. The remaining 60 (21%) totaling $13,020 had not been properly voided or reimbursed. Federal questioned costs totaled $8,283. The remaining $4,737 was state matching funds. We believe likely federal questioned costs exceed $10,000 for this condition.

In total, $576,721 was improperly paid to Children's Services; and $686,415, to the MCOs. A total of $803,576 of federal questioned costs is associated with the conditions discussed in this finding. The remaining $459,560 was state matching funds.

A review of our CAATs associated with custody (see finding 16), runaways, incarcerated youth, children under the age of three, children who were placed in medical hospitals, and children who received alcohol and drug treatment (see finding 16), revealed that our results sometimes included duplicate questioned costs. For example, costs for an incarcerated youth that was also receiving alcohol and drug treatment would be questioned twice, once in the test of incarcerated youth and once in the test of youth receiving alcohol and drug treatment. We estimate the amount of duplicate questioned costs which are included in the costs mentioned in the previous paragraph to be approximately $310,500. The estimated federal amount of the duplicate questioned costs is approximately $197,532. The state matching funds are estimated to be approximately $112,968.

Recommendation

In light of the multiple repeat findings over the years, the Director of TennCare must realize the probability of such improper payments continuing in the absence of effective controls. He should ensure that at least computer-assisted monitoring techniques are developed by the Bureau to prevent or detect payments for incarcerated youth, children on runaway status, children placed in medical hospitals, and children under the age of three. The Director of TennCare should ensure that Children's Services bills only for recipients who receive services and are eligible to receive services. In addition, the Director of TennCare should immediately follow up with the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, to comply with HHS's recommendation.

Management's Comment

We concur in part. We concur that TennCare should not be paying the Department of Children's Services (DCS) for services to incarcerated youth or for services for children on leave status. The new eligibility file update system implemented July 1, 2001, when DCS children were moved to TennCare Select should be helpful in making sure that TennCare's eligibility information is current since eligibility information is systematically updated daily. We will continue to work with DCS to request their cooperation in billing only for services for which we have contracted. In fact, DCS currently performs a review of their billings during the year to determine whether inappropriate billings were made to TennCare for services to incarcerated individuals or those on leave status. When identified, these billings are adjusted to reflect only appropriate billings. We will implement procedures to improve our monitoring of DCS's billing activity to be sure that inappropriate payments requested are either denied or recouped, if payment has already occurred.

We do not concur with the finding that TennCare should not be paying DCS for behavioral health services provided to children under the age of 3. Our position on this matter has been stated in previous management responses. The implicit assumption that children under the age of 3 cannot benefit from or should not receive behavioral health services is clearly flawed. Children at these young ages who are already in custody are likely to already have or to develop serious emotional problems. Federal EPSDT law requires that children receive screening, vision, dental, and hearing services and "such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." There is nothing in the law which provides relief from this responsibility for children under 3.

Rebuttal

As stated in the audit finding, it appears that payments for children under the age of three may not be appropriate based on HHS' recommendation. The Department of Children's Services has properly voided and reimbursed most of the claims sampled and is awaiting further clarification from HHS.

Management did not address the part of the recommendation concerning their following up with HHS for clarification. We strongly recommend (and recommended in the previous audit) that since the Bureau disagrees, the Bureau follow up with HHS concerning this issue. In addition, the Director should determine why this action has not been taken.

16. TennCare incorrectly reimbursed the Department of Children's Services over $1.1 million for services that are covered by and should be provided by the behavioral health organizations

Finding

As noted in the prior two audits, TennCare has continued to incorrectly reimburse the Department of Children's Services (Children's Services) for services that are covered by and should be provided by the behavioral health organizations (BHOs). When TennCare began (January 1, 1994), TennCare contracted with Children's Services to provide all behavioral treatment for children in state custody or at risk of state custody. On July 1, 1996, TennCare contracted with the BHOs to provide some behavioral health treatment for children in state custody or at risk of state custody. However, the TennCare waiver was not amended to define the responsibilities of Children's Services.

Management concurred in part with the prior audit finding and stated, "We continue to work with DCS and the BHOs to clarify coverage of benefit issues between the two." Management indicated that it had specifically identified to DCS and the BHOs which costs are allowable and which are not. Management also stated that TennCare would "continue to review the monitoring and claims processing procedures to improve detection of unallowable services." Although the Department of Finance and Administration's (F&A's) Office of Program Accountability and Review (PAR) has looked for more types of unallowable payments, testwork revealed that the payment problems still exist. TennCare has chosen to rely solely upon Children's Services to bill TennCare only for children in state custody. Although TennCare staff held meetings with DCS and BHO representatives to clarify benefit issues, problems still exist.

In accordance with its agreement with TennCare, Children's Services contracts separately with various practitioners and other service providers to provide Medicaid services not covered by the BHOs that are also under contract with TennCare. Children's Services pays these service providers for Medicaid services (enhanced behavioral health services) and non-Medicaid services (housing, meals, and education) directly. Children's Services then should bill TennCare for the reimbursement of only the Medicaid services. During the year ended June 30, 2001, TennCare paid approximately $122 million in fee-for-service reimbursement claims to Children's Services.

TennCare contracts with the BHOs to provide the basic and enhanced behavioral health services for children not in state custody as well as basic behavioral health services for children in state custody. TennCare has also contracted with the BHOs to provide all services to prevent children from entering state custody. In addition, TennCare has contracted with the BHOs to provide the first $30,000 of alcohol and drug treatment for children in state custody. All behavioral services for children not in state custody should be provided through the TennCare BHOs. Enhanced behavioral health services for children in state custody should be provided by Children's Services.

Since TennCare still has not implemented procedures to identify services covered by the BHOs for children not in state custody or at risk of state custody, TennCare has again paid both the BHOs and Children's Services for services for children not in state custody.

TennCare has made payments to Children's Services for enhanced behavioral health services for children not in state custody during the dates of service. Using computer-assisted auditing techniques (CAATs), auditors performed a data match comparing payment data on the Bureau of TennCare's system to custody records from the Tennessee Kids Information Delivery System (TNKIDS). The results of the data match indicated that TennCare had improperly paid $363,800 to DCS for the year ended June 30, 2001, for children who were not in the state's custody during the dates of service billed to TennCare. Federal questioned costs totaled $231,440. The remaining $132,360 was state matching funds.

In addition, a sample of 60 children from a listing totaling $4,590,432 which had mismatched names, dates of birth, and/or social security numbers was selected. Further review of these names revealed that all 60 children had a record in TNKIDS. However, of these 60 children – representing $453,194 of the $4,590,432 – $47,821 was paid to DCS for dates of services during which time the child was not in custody per the related record in TNKIDS. Federal questioned costs totaled $30,423. The remaining $17,398 was state matching funds.

Furthermore, TennCare has incorrectly made payments to Children's Services for alcohol and drug treatment provided to children in state custody by Children's Services. However, the BHOs are contractually responsible for the first $30,000 of such expenditures. Neither TennCare nor Children's Services has a mechanism for identifying children who have already received $30,000 of these services provided by the BHOs. Thus, TennCare improperly paid Children's Services $769,055 for the year ended June 30, 2001, for services covered by the BHOs. Federal questioned cost totaled $489,254. The remaining $279,801 was state matching funds.

We also found that TennCare made some payments to DCS for providers who billed the BHO and then billed DCS for the same child for the same dates of service. While some portion of these payments might be appropriate, the absence of written policies and procedures regarding instances where such a payment is allowable makes this determination very difficult. In some cases, we found that the BHO was billed by one provider and DCS was billed by a different provider for the same child for the same dates of service. In other cases, we found that the BHO and DCS were billed by the same provider.

In total, as a result of the conditions described in this finding, $1,180,676 was improperly paid to Children's Services. A total of $751,117 of federal questioned costs is associated with the conditions discussed in this finding. The remaining $429,559 was state matching funds.

A review of our CAATs associated with custody, runaways (see finding 15), incarcerated youth (see finding 15), children under the age of three (see finding 15), children who were placed in medical hospitals (see finding 15), and children who received alcohol and drug treatment revealed that our results sometimes included duplicate questioned costs. For example, costs for an incarcerated youth that was also receiving alcohol and drug treatment would be questioned

twice, once in the test of incarcerated youth and once in the test of youth receiving alcohol and drug treatment. We estimate the amount of duplicate questioned costs which are included in the costs mentioned in the previous paragraph to be approximately $310,500. The estimated federal amount of duplicate questioned costs is approximately $197,532. The state matching funds are estimated to be approximately $112,968.

Recommendation

The Director of TennCare should ensure that monitoring techniques are implemented to detect and prevent unauthorized payments for children in state custody, children not in state custody, and children at risk of being in state custody. Controls should be developed and implemented to ensure the BHOs and Children's Services are paid only for services for which they are responsible. In addition, policies should be developed and implemented to describe instances where providers may bill the BHO and Children's Services for the same dates of service for the same child.

Management's Comment

We concur in part. We concur that TennCare should not be paying the Department of Children's Services (DCS) for services for incarcerated youth, runaways, or children who are not in custody. During the past year there have been extraordinary efforts made to link data from DCS and TennCare. DCS/TennCare file updates had been occurring off-line, approximately every two weeks. On July 1, 2001, all DCS children were moved into TennCare Select. Eligibility information is now updated systematically on a daily basis. This change alone has greatly improved monitoring of a child's custody status. In addition, we will continue to work with DCS to request their cooperation in billing only for services for which we have contracted. We will implement procedures to improve our monitoring of DCS's billing activity to ensure that inappropriate payments requested are either denied or recouped, if payment has already occurred.

We do not concur, however, with other assumptions made in the finding. These assumptions may be based on an incomplete understanding of arrangements that have been in place for many years. TennCare pays DCS through the State's Title V agreement for "children's therapeutic intervention services." These services are defined as the portion of a child's residential placement day at DCS that qualifies as "treatment." Non-Medicaid services are not included in this payment. The portion of the child's residential placement day that is considered "treatment" is calculated on the basis of a random moment time study that has been approved by CMS. This is a legitimate payment that does not duplicate other payments for services that a child might receive while he or she is in DCS custody. It does not include payment for room and board or other services that are not "treatment." This arrangement allows the state to take advantage of the availability of federal funding for treatment services that would otherwise be provided at 100% state expense.

A residential treatment provider who is being paid by DCS should obviously not be billing the BHO also for residential treatment. It would be unlikely that this would occur, however, since residential treatment for custody children is clearly the responsibility of DCS. It is entirely possible that a child could be in a DCS residential placement, with the treatment portion of his or her day being paid for by TennCare, and still access services from the BHO without duplicate payments being involved.

Example: *A child is in therapeutic foster care at DCS, with the therapeutic portion of his/her day paid for by TennCare. The child sees a psychiatrist on a day when he is in therapeutic foster care. The psychiatrist's services are paid for by the BHO. The services that are being provided are different, and payment for both is appropriate.*

"Children's therapeutic intervention services" could also include alcohol and drug treatment. Thus a child could be in DCS custody, in a DCS residential placement, with the portion of his day that is alcohol and drug treatment related properly billable to TennCare.

We recognize that the arrangements between DCS and TennCare are complex, and we plan to produce a manual in the coming year that will outline written policies and procedures for these interactions.

The Program Integrity Unit of the Office of Health Services has worked with representatives of DCS, the BHOs, TennCare, and the Comptroller's Office to review issues from the June 30, 2000, audit finding that are similar to those mentioned in this finding. This review is still in process, but at this time it has been determined that of the $13 million in billings questioned in the previous audit report, less than $100,000 in billings may be duplicates. Additional research is being performed to determine the appropriate action to take for resolution of these items. Also as a result of this review it was determined that services for children in DCS Continuums 3 and 4 were the most likely to be billed to both DCS and the BHO. Therefore, in October 2001, TennCare Fiscal Services began running a quarterly data match against BHO encounter data for children in DCS Continuums 3 and 4 to search for billings that may be considered inappropriate. When indicated, additional research is performed to ensure billings are appropriate.

Rebuttal

As stated in the finding, in the absence of written policies and procedures regarding payments made to DCS and the BHO for the same child for the same dates of services, we cannot determine which payments are allowable. Management appears to agree since it plans to produce a manual that will outline written policies and procedures for these interactions.

While management indicates that "children's therapeutic intervention services" could include alcohol and drug treatment while the child is in custody, management did not address the issue that the first $30,000 of these services should be provided by a BHO.

Management, in referring to the prior-year audit report, states that "of the $13 million in billings questioned in the previous audit report, less than $100,000 in billings may be duplicates." However, the previous audit report identified only approximately $3.6 million as possible duplicate billings. The $13 million referred in the prior audit finding also included payments for children not in state custody, payments for Hometies services that should be provided by the BHOs, and payments for alcohol and drug treatment.

17. TennCare should exercise its responsibility to ensure the Department of Children's Services' new payment rates are implemented

Finding

As noted in three previous years' audit findings, with which management concurred, TennCare has not ensured that the Department of Children's Services (Children's Services) has established federally approved Medicaid treatment rates for services provided for children in state custody. In response to the prior audit finding, management stated it would "again request a response from HCFA [the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration]."

Children's Services completed a new time and cost study in January of 2000, to serve as the methodology for determining actual cost associated with the treatment of children in its custody. On November 5, 2001, the federal Department of Health and Human Services' Division of Cost Allocation approved an amendment to the Department of Children's Services cost allocation plan, effective July 1, 2000. This amendment, which establishes standard rates based on levels of service to be billed to TennCare and documents the methodology for determining those rates, is awaiting implementation and retroactive application by Children's Services.

TennCare has relied on Children's Services to determine the Medicaid treatment rates paid to the Medicaid service providers for children in the state's custody. Children's Services pays the Medicaid service providers for all Medicaid (treatment) and non-Medicaid services (housing, meals, and education) directly and then bills TennCare for the reimbursement of Medicaid services.

Testwork performed on the billing rates used during the audit period revealed that in 23 of the 30 billings tested (77%), the amount billed to TennCare for treatment cost was greater than 50% of the total amount paid to the provider. In many instances, Children's Services was billing TennCare 70% to 100% of the total amount paid to the provider, and management at Children's Services could not substantiate the rates being used. It appears the amount paid to the provider included room and board and education costs that are not allowable costs to TennCare. As a result, TennCare has been reimbursing Children's Services for non-Medicaid services.

Recommendation

The Director of TennCare should ensure that Children's Services promptly implements the federally approved rates for treatment costs associated with children in state custody.

Management's Comment

We concur. The Department of Children's Services has provided TennCare with rates consistent with the federally approved methodology. TennCare is currently loading these rates and will be operating under them by April 2002.

18. TennCare has not adequately monitored TennCare-related activities at the Department of Children's Services

Finding

The previous four audits have reported that TennCare has not adequately monitored TennCare funded activities of the Department of Children's Services (Children's Services). TennCare uses the services of the Department of Finance and Administration's Division of Resource Development and Support (RDS) to monitor Children's Services. The prior year's audit finding addressed four specific areas where RDS did not follow the requirements of their agreement with TennCare:

- TennCare did not ensure that RDS was aware of all possible unallowable costs associated with certain Children's Services payments.
- RDS did not test service providers to ensure that all provider enrollment qualifications were met.
- RDS did not test the accuracy of Children's Services billing rates.
- RDS did not submit quarterly monitoring reports.

The first two areas were corrected in the audit period; however, RDS still has not tested the accuracy of Children's Services billing rates and did not submit a monitoring report for the first quarter of the fiscal year. RDS has been hampered in testing billing rates by TennCare's not having approved billing rates (finding 17).

Management concurred with the prior audit finding, as they had with previous findings, and stated that TennCare appointed a Children's Services liaison who has met regularly with Children's Services to discuss billing codes, billing practices, coverage of services, and other related issues. Management also stated that the liaison had met with RDS monitoring staff to clarify issues and discuss reports. Also, management stated that TennCare would continue to work with RDS monitoring staff to strengthen monitoring of Children's Services. Although

during audit fieldwork evidence of these actions was provided, testwork revealed that monitoring still needs improvement.

In accordance with the agreement between Children's Services and TennCare, Children's Services contracts separately with various practitioners and service providers to provide health care benefits not provided by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) under contract with TennCare. Children's Services pays these providers and bills TennCare for reimbursement. For the year ended June 30, 2001, TennCare paid approximately $122 million to Children's Services in fee-for-service reimbursement claims.

Because of the inadequate monitoring of Children's Services, TennCare cannot ensure that the amounts billed are correct and allowable.

Recommendation

The Director of TennCare should ensure that RDS properly performs its responsibilities under the monitoring agreement. The Director of TennCare should require quarterly reports from RDS. He should also provide reasonable criteria for RDS to use to determine the accuracy of Children's Services' billing rates.

Management's Comment

RDS did not test the accuracy of Children's Services billing rates.

We concur. Testing of DCS billing rates was discussed with RDS in a planning meeting. It was determined that TennCare would be responsible for monitoring these rates. New DCS rates are currently reviewed by the Comptroller of the Treasury, under contract with TennCare. TennCare will select a sample of claims on a periodic basis and test the rates billed by DCS. Any discrepancies will be resolved with DCS.

RDS did not submit quarterly monitoring reports.

We concur. TennCare will work with RDS to ensure that quarterly reports are submitted.

19. TennCare continues to fail to adequately monitor the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded and Developmentally Disabled

Finding

As noted in the prior two audits, the Bureau of TennCare's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver) under Section 1915(c) of the Social Security Act is still inadequate to

provide the federally required assurances of health and welfare and of financial accountability and to ensure fulfillment of TennCare's contract responsibilities.

TennCare has not developed a formal monitoring plan (including the necessary policies and procedures) to ensure that all the required areas are adequately monitored and that other procedures are performed to provide the required federal assurances. Specifically, TennCare has not reported the required assurances in a timely manner to the Centers for Medicare and Medicaid Services (CMS) and has not provided adequate monitoring to support the health, welfare, and financial accountability section of the report. The Division of Mental Retardation Services (DMRS), which oversees the program for TennCare, is contractually required to monitor the HCBS MR/DD waiver's Medicaid service providers. See finding 20 for further details regarding this matter.

Section 1915(c)(2)(A) of the Social Security Act requires that

> necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services.

The HCBS MR/DD waiver that has been in effect since the 1980s requires TennCare to have a formal plan of monitoring in place to ensure the health and welfare of individuals in the waiver. The waiver further requires that all problems identified by the monitoring process will be addressed by TennCare in an appropriate and timely manner, consistent with the severity and nature of deficiencies. The HCBS MR/DD waiver also requires TennCare to provide assurances of financial accountability for funds expended for home- and community-based services provided under the State Medicaid Plan. The monitoring plan must include filing the required federal reports.

Testwork revealed that TennCare still does not appear to have adequate personnel to perform the monitoring needed to support the federally required assurances. The Bureau of TennCare had only one permanent monitor, who is a registered nurse, for the approximately 4,500 recipients of waiver services, 462 service providers, and DMRS during the year ended June 30, 2001. While DMRS has contracted with the Office of Program Accountability and Review to perform fiscal monitoring for the program, TennCare performed no procedures to ensure that the monitoring was adequate. In a letter of correspondence from the CMS to the Bureau of TennCare dated October 25, 2001, in reference to the HCBS MR/DD waiver, CMS noted that "sufficient staff to monitor administration and operation of the program is still not in place."

Section 1915(c)(2)(E) of the Social Security Act requires the state to provide the Secretary of the U.S. Department of Health and Human Services (HHS) with an annual report, the Health Care Financing Administration (HCFA) 372 report, on the impact of the waiver on the type and amount of medical assistance provided under the state plan and on the health and welfare of the recipients, including TennCare's assurances of health and welfare and of financial accountability under the waiver.

Management concurred with the prior audit finding and stated they would draft policies to address the timely submission of the HCFA 372 report (Annual Report on Home and Community-Based Services Waivers report). However, the policies concerning the HCFA 372 reports were in draft stage during the audit period.

For the year ended June 30, 2000, TennCare once again did not submit the HCFA 372 Report within 181 days after the last day of the waiver period as required by the HCFA *State Medicaid Manual*, Section 2700.6 E., Submittal Procedures for Due Date. The Home and Community Based Services waiver HCFA 372 reports that should have been submitted by December 28, 2000, were not submitted until August 20, 2001. The HCFA 372 report for the American Disabled for Attendant Programs Today (ADAPT) waiver (Davidson, Hamilton, and Knox counties) that should have been submitted by April 30, 2001, had not been submitted by December 4, 2001. The respective HCFA 372 (S) reports for fiscal year 1999, which were due the year after the HCFA 372 reports, were submitted at the same time. Both reports were submitted after the required due date.

In addition to not having formal monitoring policies and procedures, TennCare has also failed to meet specific contractual monitoring responsibilities. TennCare does have six specific monitoring responsibilities for the HCBS MR/DD waiver in its contract with DMRS. However, TennCare did not comply with the five that are still applicable. One of the responsibilities, related to reviewing preadmission evaluations (PAEs) developed by DMRS, is no longer applicable because DMRS stopped and TennCare began approving these PAEs in June 2000. In response to the prior audit finding, management stated they would revise the contract with DMRS to reflect the current PAEs approval process. However, TennCare did not modify the existing contract to exclude the requirement for TennCare to review the random sample of PAEs. The contract also includes these other responsibilities for TennCare:

1. TennCare is to monitor the plans of care for persons receiving waiver services by reviewing a sample of the plans of care for recipients in the program during the annual state assessment. Testwork revealed that the TennCare monitoring staff did not review plans of care for the year ending June 30, 2001.

2. TennCare is required to monitor DMRS' policies for implementation and coordination of the waiver services approved by Health and Human Services (HHS). However, TennCare has not adequately monitored the policies of DMRS for implementation and coordination of the waiver services. For example, TennCare had no role in the approval process of the *Operations Manual for Community Providers* in use during the audit period, which is the policy manual used by DMRS.

3. Per the contract, TennCare is to provide quality assurance monitoring to evaluate performance of DMRS. However, TennCare has not performed quality assurance monitoring of DMRS.

4. TennCare is to perform periodic audits of client records to validate the findings of the DMRS Quality Enhancement review, and report the results to DMRS with action

required or needed to rectify deficiencies in a timely manner. This report is an annual statewide assessment of DMRS' overall performance in the waiver. TennCare does not have guidelines to use when performing periodic audits of client records. Furthermore, TennCare has not performed the state assessment. The Compliance Review conducted by CMS for the year ending June 30, 2001, stated, "The Medicaid Agency indicated that it conducts reviews and issues an annual report. However, a report has not been issued from the Medicaid Agency to DMRS in 5 years."

5. TennCare is to assure the health and welfare of the individuals served in the waiver, through monitoring of quality control procedures described in the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled. However, this monitoring was not performed.

In addition, the HCBS MR/DD waiver contract states that marketing shall be the responsibility of DMRS. DMRS will send to TennCare "for prior written approval all of its marketing plans, procedures and materials relating to services to be provided. . . ." However, no marketing plans were submitted by DMRS during the audit period.

These critical contractual responsibilities have not been fulfilled. As a result, TennCare cannot support the required federal assurances for health and welfare and for financial accountability. Also, TennCare's inadequate monitoring increases the risk that other federal requirements are not met.

Recommendation

The Director of TennCare should develop waiver monitoring policies and procedures to ensure that a formal monitoring plan exists to provide the required health and welfare and financial accountability assurances to CMS. The Director should ensure that the HCFA 372 reports and contractually required reports are submitted in a timely manner. The Director should monitor the process to ensure adequate assurances of health and welfare and of financial accountability are made to CMS. The Director should ensure that an adequate number of appropriately trained staff are available to perform monitoring. The Director should ensure that all contract monitoring responsibilities are satisfied.

Management's Comment

We partially concur.

Overview—Building Capacity: TDLTC is in the process of establishing a Quality Monitoring Unit with sufficient staff to monitor the MR waiver and other waiver programs. Policies, survey tools and procedures for monitoring are under development. Development of a formal plan and associated policies has been delayed to a large part due to resource issues. There have been a number of targeted complaint investigations required by CMS. Available staff have

been devoted to completing these investigations, implementing elements of the CMS corrective actions plan and hiring/training new QM staff. A meeting is scheduled for February 14, 2002 to develop an interim QM plan. A permanent QM plan will be developed upon hiring a QM manager. The plan will include annual review of a sample of plans of care, monitoring of DMRS policies for implementation, coordination of waiver services and review of the operations manual for community providers.

CMS 372 reports: Systems issues were resolved during the last fiscal year to allow the report to be available to TDLTC on a timely basis. However, requirements to submit a QA summary have delayed submission to CMS until reports on QM activities were available. TDLTC waiver staff are currently completing all outstanding reports for submission to CMS by the end of this month. With increased QM staff in the TDLTC, reports should be timely from this point forward. Policies for submission of 372 reports are no longer draft policies. In fact, it was an oversight that the "draft" notation was not removed from the copy of the policy supplied to the auditors. The policies provided were and are written representations of the process that has always been followed, including the time period during the audit period.

Sufficiency of monitoring staff: As previously mentioned, a QM Unit is being established with a number of new positions approved to staff the unit. Staff hired to date include the following: an RN Complaint Coordinator, 3 RN Regional Quality Monitors, a QM Data Base Coordinator, and two in-house RN QM Coordinators. In addition, two nurse auditors from the Comptroller's Office have been assigned to the TDLTC and will be utilized to perform post-payment reviews. In addition, TDLTC is attempting to hire five Mental Retardation Program Specialist 3 positions and a QM Unit Manager.

Reviews of care: Surveys done for the audit period did include reviews of a sample of enrollee plans of care. However, we concur that the written report was not submitted timely to DMRS. The report is in draft form awaiting review and revision by the TDLTC director. Report findings have been discussed with DMRS and are in large part addressed by the findings included in the CMS audit report. However, the report will be finalized by the end of March and will be submitted to DMRS with a directive to correct any deficiencies not currently being addressed by the Corrective Plan developed as a result of the CMS audit.

TDLTC is now reviewing all policies prior to issuance to waiver service providers. In addition, TDLTC is reviewing the new operations manual and making revisions as appropriate. The new *Operating Guidelines* will be reviewed in its entirety and issued to providers by July 1, 2002. Sections are currently being issued as replacement sections as approved by TDLTC.

State Assessment surveys and targeted reviews completed by TDLTC QM staff include evaluation of both providers and administrative lead agencies. Reports will, from this point forward, address recommendations for DMRS as well as recommendations for actions to resolve provider deficiencies. We do not concur that DMRS has not been monitored; however, we do concur that reports have not been timely. The last report issued for FY 96/97 was issued late. In attempt to bring reports up to date, findings for FY 98/99 and 99/00 have been included in one report that is currently in draft form. As previously indicated, this report will be finalized and

issued by the end of March, 2002. As noted in the Corrective Plan, TDLTC will continue to conduct targeted reviews and issue reports to DMRS for the current and past fiscal year and will resume State Assessments in fall 2002 for the current fiscal year. Audit tools and policies, as well as a formal monitoring plan will be developed and implemented by that time. Current and future targeted and state assessment reviews will include review and evaluation of DMRS QE activities.

Rebuttal

Management has concurred with this audit finding in the previous two audits.

Reviews of Care:

The contract requirement referenced in the finding requires TennCare to monitor plans of care for individuals "during the state assessment." Upon receiving this response, we asked management for documentation that they examined a sample of enrollees' plans of care. Management provided documentation that plans of care were reviewed during investigations of providers, but not during the state assessment as required by the contract. In addition, as stated in the finding, TennCare has not performed the annual state assessment.

We agree that DMRS has been monitored. However, as noted in this finding, there were deficiencies in the monitoring effort.

20. TennCare should ensure that the Division of Mental Retardation Services provides adequate monitoring of the waiver for Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled

Finding

As noted in the prior two audits, the TennCare Bureau did not ensure that the Division of Mental Retardation Services (DMRS) complied with its contract monitoring requirements for the Medicaid Home and Community Based Services (HCBS) waiver for the Mentally Retarded and Developmentally Disabled. The contract between the TennCare Bureau and DMRS requires DMRS to give assurance that necessary safeguards will be taken to protect the health and welfare of the recipients of home- and community- based services and assurance of financial accountability for funds expended for home- and community-based services. Management concurred with the finding and stated,

> Based on recommendations from the prior audit, DMRS developed monitoring procedures and instruments for use with home health and other alternative providers. These procedures were implemented on July 1, 2000, and those providers are currently being monitored. . . . As of July 1, 2000, responsibility for fiscal monitoring was transferred to the Department of Finance and Administration, Program Accountability Review (PAR) unit. The PAR unit is

staffed by qualified personnel who conduct thorough fiscal monitoring of provider agencies and the results are communicated to the regional office where action can be taken on the findings when warranted.

According to the HCBS MR/DD waiver, the health and welfare assurances to be provided include assurance of adequate standards for all types of providers that furnish services under the waiver and assurance of state licensure requirements being met on the date the services are furnished.

Testwork revealed that a Memorandum of Understanding Agreement was put in place between DMRS, Finance and Administration, and the PAR group to perform fiscal monitoring for the HCBS Mentally Retarded and Developmentally Disabled (MR/DD) providers. The effective date of the contract was August 1, 2000, and the PAR unit did perform adequate fiscal monitoring for waiver recipients and service providers except for alternative providers during the audit period. Testwork also revealed that DMRS had a monitoring tool in place to monitor the waiver's home health agencies and carried out the monitoring of these providers. However, the monitoring tool was not approved by TennCare as required by TennCare's contract with DMRS which states that TennCare will monitor "policies and procedures for implementation and coordination of the waiver services."

In addition to fiscal monitoring we also examined DMRS's programmatic monitoring.

Although testwork revealed that DMRS is adequately monitoring to ensure that the traditional long-term care providers have the necessary safeguards in place to protect the health and welfare of waiver recipients, there were no monitoring procedures in place for monitoring alternative providers such as nutritionists, therapists, and dentists.

Recommendation

The Director of TennCare and the Deputy Commissioner over DMRS should ensure that DMRS complies with contractual requirements for assurances of health and welfare. The Director should ensure that all alternative providers are monitored. To ensure adequate monitoring is provided, DMRS monitoring policies and procedures should be approved by TennCare.

Management's Comment

We concur. As mentioned in the response to other audit findings, TDLTC is establishing a Quality Monitoring Unit. Staff in this unit will evaluate the DMRS QE system and provide recommendations for improving the process and correcting deficiencies as is appropriate. A major focus will be on ensuring follow-through sufficient to assure timely correction of deficiencies noted.

Regarding DMRS monitoring tools, policies and procedures, TDLTC has reviewed the Quality Monitoring section of the DMRS Operating Guidelines. QE tools are undergoing further revision and TDLTC is participating in this process. The DLTC Regional Monitoring Nurse participated in testing the current QE tool for Home Health providers and provided recommendations for revision to the form and process during the testing period.

21. TennCare is still failing to pay claims for services provided to the mentally retarded and developmentally disabled in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled

Finding

As noted in the prior two audits, TennCare has allowed other state officials outside the Bureau of TennCare to contract with and to pay Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD waiver). The *Code of Federal Regulations*, Title 42, Part 431, Section 10(e)(3), allows other state and local agencies or offices to perform services for the Medicaid agency. As a result, the Bureau of TennCare has contracted with the Division of Mental Retardation Services (DMRS) (both the bureau and DMRS are within the Department of Finance and Administration) to oversee the HCBS MR/DD waiver program. However, DMRS has not complied with HCBS MR/DD waiver requirements regarding claims for services.

The prior finding noted that

- TennCare did not contract directly with providers and allowed DMRS to contract directly with these providers. Furthermore, DMRS did not obtain written approval from TennCare before entering into contracts with providers, nor did it submit copies of provider contracts to TennCare before their execution. In addition, TennCare has inappropriately paid DMRS as a Medicaid provider. DMRS in turn has treated the actual Medicaid service providers as DMRS vendors;
- TennCare did not make direct payments to providers of services covered by the waiver and allowed claims to be processed on a system not approved as a Medicaid Management Information System;
- TennCare allowed DMRS to pay waiver claims outside the prescribed waiver arrangement; and
- TennCare allowed DMRS to pay providers for days when a waiver recipient did not receive services (leave days).

Management concurred with the prior audit finding concerning payments to providers for leave days and changed its methodology to prevent payments for leave days. However, the remaining issues continue to be problems.

Section 1902(a)(27) of the Social Security Act and the HCBS MR/DD waiver require TennCare to contract directly with the providers. The contract between TennCare and DMRS also prohibits DMRS' assignment of a contract without approval from TennCare and requires DMRS to submit copies of contracts to TennCare prior to the effective date of the contract. However, TennCare has allowed DMRS to contract directly with the Medicaid providers.

Management stated in its comments to the prior finding that a new provider agreement was developed that allows both TennCare and DMRS to sign the agreement with the provider. However, the contracts in effect during the audit period did not contain signatures by both DMRS and TennCare.

In addition, TennCare has inappropriately paid DMRS as a Medicaid provider. DMRS in turn has treated the actual Medicaid service providers as DMRS vendors. According to Medicaid principles, as described in the Provider Reimbursement Manual, Part I, Section 2402.1, DMRS is not a Medicaid provider because it does not perform actual Medicaid services.

The waiver agreement requires provider claims to be processed on an approved Medicaid Management Information System and provider payments to be issued by TennCare. However, TennCare has allowed DMRS to process claims on its own system and make payments to providers through the State of Tennessee Accounting and Reporting System (STARS).

DMRS has also paid waiver claims outside the prescribed waiver arrangement. The waiver is designed to afford individuals who are eligible access to home- and community-based services as authorized by Section 1915(c) of the Social Security Act. Typically, any claims submitted by providers for services performed for waiver recipients would be processed in accordance with all applicable federal regulations and waiver requirements, and the state would receive the federal match funded at the appropriate federal financial participation rate.

The current billing and payment process is as follows:

1. Medicaid service providers perform services for waiver recipients.
2. Providers bill DMRS for services.
3. DMRS pays providers based on rates established by DMRS, not the rates in the waiver. TennCare has improperly allowed DMRS to use the Community Services Tracking System and STARS to pay the providers.
4. DMRS bills TennCare (as if DMRS were a provider) based on the waiver rates.
5. TennCare pays DMRS (as if DMRS were a provider) the TennCare rates using the TennCare Management Information System (TCMIS).

Management stated in the prior audit finding that they would seek clarification concerning the reimbursement of providers at negotiated rates rather than waiver-approved rates. However, according to discussions with management, TennCare did not receive a response from CMS regarding the reimbursement rates. Because TennCare has not ensured that DMRS complied with the waiver and federal regulations, TennCare paid DMRS more than DMRS had

paid the providers in 44 of 53 claims examined. TennCare paid DMRS less than DMRS paid the providers on the other 9 claims. For the 53 claims examined, TennCare paid $104,088 to DMRS, and DMRS paid the providers $84,275. As noted in finding 23, testwork on this same sample revealed that these claims were not adequately approved and/or documented. As a result, the questioned costs relating to the inadequate approval and/or documentation have been reported in finding 23. No additional questioned costs relating to the differences in payments will be reported in this finding.

Testwork and auditor inquiry also revealed a new issue regarding DMRS' contracting with providers who provide a service described as community participation (CP) combo. CP combo services are provided to individuals in the HCBS MR/DD waiver. Chapter three of the DMRS' *Operations Manual for Community Providers* permits CP combo services, which are a combination of community participation and day habilitation (services to improve the recipient's social skills and adaptive skills) services. However, the HCBS MR/DD waiver does not allow any combination of services. For example, we examined a cost plan of a waiver recipient and determined that TennCare is paying DMRS for community participation services at $13.00 per hour, when in some cases, the waiver recipient is receiving day habilitation, which should be paid at $6.65 to $8.90 per hour. As a result, for each hour when day habilitation was provided, TennCare overpaid DMRS.

By not paying providers directly, federal reimbursement has been delayed longer with DMRS paying the provider than if TennCare had paid providers directly in accordance with federal regulations. In addition, as noted earlier in the finding, in most cases DMRS pays the provider less than TennCare reimburses DMRS. Most of the actual providers are contracting and being paid rates less than the approved waiver rates. As a result, DMRS is profiting on these claims at the expense of the actual providers. Otherwise, TennCare's higher payments to DMRS may result in higher costs than necessary for the program when actual providers are contracting to provide services at rates less than the waiver approved rates.

Recommendation

The Director of TennCare should take immediate action to comply with all federal requirements, including those in the waiver, to ensure that all federal financial participation claimed is allowable. The Director should ensure that TennCare pays providers in accordance with the waiver and only for allowable services. The Director should ensure that the federal financial participation drawn is based upon waiver approved rates or the actual amount paid to the ultimate providers of services if agreements are reached with providers to provide services at rates less than the waiver approved rates. TennCare should process claims on the approved Medicaid (TennCare) Management Information System and pay providers directly. The Director should ensure that services are not combined to conflict with the HCBS MR/DD waiver.

Management's Comment

We partially concur.

Provider agreements: The format for provider agreements has been revised. It is now a three-way contract between the provider, TennCare, and DMRS. For the 2002 fiscal year, provider agreements were submitted by DMRS for TennCare signature prior to execution. The provider agreements are currently being matched against provider lists to ensure that a signed contract is on file at TDLTC for all MR waiver providers. TennCare is currently reviewing DMRS enrollment processes and has been signing off on new provider approvals since July 2001.

Provider payment: Federal regulations allow providers to reassign payment to DMRS. Signed provider agreements include reassignment of payment to DMRS. However, we concur that the payments made by DMRS were not made via an approved MMIS system. TDLTC has had meetings with TennCare Information Systems staff, Fiscal staff and Provider Services staff to begin developing mechanisms for direct provider payment. In regional meetings with MR waiver provider staff (held in August/September and December 2001), providers were informed that in the future, payments would be issued directly by TennCare with an option to reassign payment to DMRS. In regional meetings scheduled for March 2002, TennCare Provider enrollment forms will be given to providers so that providers can complete the forms, submit them to TennCare and be put on the systems file as a TennCare provider.

Payment of DMRS as a provider: We concur that DMRS has been paid in accordance with the rates in the waiver and that in most cases, the rates paid to providers by DMRS have been different. The rates in the approved waiver document are estimated average rates. It is common for states to contract with providers for rates that are different than the average rates in the waiver to accommodate for differences in regional costs of living and staffing costs. The goal is for the rates paid to average what has been approved in the waiver application for FFP. The amount paid to DMRS in excess of what was paid providers was intended to provide reimbursement to DMRS for administrative costs of daily operations for the waiver program. The amounts realized via this mechanism do not, in fact, cover all the administrative costs incurred by DMRS; therefore, DMRS is not "profiting" from this arrangement. However, we intend to include in TennCare's contract with DMRS a description of payment for administrative services in accordance with the cost allocation plan approved by CMS (verbal notification has been received approving the cost allocation plan and official notification is expected soon). The cost allocation plan includes a process to perform a year-end cost settlement.

CP combo rates: CMS has indicated that it is permissible to allow a combination of day services, as long as the provider is not paid for two day services that are billed during the same period of time. TDLTC will have further discussions with CMS and DMRS pertaining to the way DMRS has elected to pay for combination services. The system will be revised as necessary to comply with federal regulations and ensure appropriate payment for services rendered. TDLTC will monitor for overpayment via survey and post payment review.

Rebuttal

TennCare management has concurred with this audit finding in the previous two audits.

Provider payment: The provider agreements in effect during the audit period required the provider to accept payment from DMRS. The agreements did not give the provider the opportunity to be paid through TCMIS, the approved Medicaid Management Information System. In a report of a compliance review conducted for the HCBS waiver dated July 27, 2001, CMS stated:

> Section 1902(a)(32) requires that providers have the option of receiving payments directly from the State Medicaid Agency. The state should modify its payment system to comply with this requirement.

Payment of DMRS as a provider: Management stated in their response:

> The amounts realized via this mechanism do not, in fact, cover all the administrative costs incurred by DMRS; therefore DMRS is not "profiting" from the agreement.

While DMRS may not be receiving enough through the claims reimbursement process to pay their providers and fund all administrative costs, it should be noted that administrative costs should be claimed using a cost allocation plan (see finding 22).

Under the current arrangement with the Bureau, the profit (the excess of TennCare's reimbursments to DMRS over DMRS' payments to providers) from the reimbursement of treatment costs is inappropriately being used to pay administrative costs.

The federal government has noted this inappropriate practice of using claims reimbursement to partially fund administrative costs in a report of a compliance review conducted for the HCBS waiver dated July 27, 2001, in which CMS stated:

> The State Medicaid Agency reimburses the DMRS for the services and DMRS reimburses the providers. It appears that, in some cases, the DMRS reimburses providers less than the payment received from the Bureau of TennCare. Governmental agencies may not profit by reassignment in any way, which is related to the amount of compensation furnished to the provider (e.g., the agencies may not deduct 10 percent of the payment to cover their administrative costs). To do so places the agency in the position of "factor" as defined in 42 CFR 447.10(b). Payment to "factors" is prohibited under 42 CFR 447.10(h).

22. The Bureau of TennCare has continued to operate without an approved cost allocation plan, which has prevented the collection of federal matching funds for indirect costs for the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled

Finding

As noted in the previous two audits, TennCare should have a Medicaid cost allocation plan to provide for the recovery of administrative costs associated with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD) program. Management concurred with the prior audit finding and stated,

> A letter was submitted to HCFA [now the Centers for Medicare and Medicaid Services (CMS)] in the spring of 2000 requesting approval of a cost allocation method for the MR/DD waiver. HCFA responded that the letter should be submitted to the Department of Health and Human Services (HHS). The letter to HHS was submitted in June of 2000. They in turn sent the letter to HCFA financial experts for review. Consequently, we have not received approval from HCFA to proceed with the cost allocation plan.

In response to the prior audit finding, TennCare did not draw federal funds related to these costs during the current audit period. A cost allocation plan was submitted to CMS, but without approval from CMS the costs cannot be claimed. Management stated that there have been ongoing discussions with CMS regarding this matter, and this was confirmed with a CMS auditor. Currently the Department of Finance and Administration's Division of Mental Retardation Services (DMRS) has the responsibility for day-to-day management of the HCBS MR/DD waiver program. The audit of the Bureau of TennCare revealed that DMRS had indirect costs for the supervision of the HCBS MR/DD program totaling $29,539,226 for the year ended June 30, 2001. Because TennCare did not have an approved cost allocation plan, the state was not able to recover $14,769,613 in federal matching funds.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments, Attachment D, Public Assistance Cost Allocation Plans*, requires an approved cost allocation plan for all direct and indirect administrative costs for public assistance programs. Without an appropriately amended and approved plan, the Bureau of TennCare is not eligible to recover these costs from the federal grantor.

Recommendation

The Director of TennCare should follow up with the federal grantor as quickly as possible to obtain an approved cost allocation plan.

Management's Comment

We concur. Representatives from TennCare, the Department of Mental Health and Developmental Disabilities, and the Division of Mental Retardation Services have worked with CMS since submission of the plan to obtain approval. CMS has recently indicated verbal approval for the cost allocation plan submitted in 2000, but written approval has not yet been received. Approval of the plan will allow the State to claim federal matching funds at a 50% administrative rate.

23. TennCare has still failed to ensure that adequate processes are in place for approval of the recipient and for the review and payment of services under the Medicaid Home and Community Based Services Waiver

Finding

As noted in the prior two audits, TennCare has not ensured that the Division of Mental Retardation Services (DMRS) appropriately reviews and authorizes the eligibility of and the allowable services for recipients under the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled (HCBS MR/DD) Waiver and the Elderly and Disabled waivers. DMRS allowed providers to render services to recipients before proper eligibility preadmission evaluations were performed and documented and before services were reviewed and authorized. In addition, claims were paid for unallowable and/or unauthorized services, and the required service plan and cost plans were inconsistent.

In response to the prior finding, management stated:

> Based on recommendations from the prior audit, DMRS modified its Service Plan review and authorization process. DMRS Regional Directors now ensure that approval of services is adequately documented on each individual's service plan. Every service plan is reviewed, approved and signed. The revised process was implemented in the summer of 2000. . . . Cost plan and service plan date consistency has likewise improved with the revised process. . . . A draft policy has been written to address the review of PAEs [preadmission evaluation] for those applying for TennCare reimbursed programs for the mentally retarded. . . .

However, as noted below, the problems have continued.

A sample of 60 claims for the HCBS MR/DD Waiver and the Elderly and Disabled waivers was selected. Fifty-three claims were for individuals enrolled in the HCBS MR/DD Waiver. The remaining seven individuals were enrolled in the Elderly and Disabled waivers.

For the 60 claims, we examined the following documentation:

- the related PAEs for all waiver recipients (60 claims);

- the required physical and psychological exams for HCBS MR/DD recipients (53 claims);
- the independent support plans for HCBS MR/DD recipients (53 claims);
- the service plans for all waiver recipients (60 claims);
- the cost plans for HCBS MR/DD recipients (53 claims);
- the recertification for all waiver recipients (60 claims);
- other required supporting documentation for all waivers (60 claims); and
- service plans for independent support coordination (37 claims).

In a review of the waiver eligibility process, testwork revealed that for 7 of 53 claims tested (13%) for HCBS MR/DD recipients, the PAEs and the required physical exam and/or psychological exam had one or more of the following deficiencies:

- The PAE was not on file, or the PAE was not signed. In DMRS' *Operations Manual for Community Providers*, chapter 1 requires a preadmission evaluation (PAE) to be properly completed for each recipient, and chapter 2 requires service plans to be authorized before entry into DMRS' Community Services Tracking System as approved.
- There was no evidence that a physical and/or psychological exam was performed. Furthermore, for 7 of 53 claims tested (13%) for HCBS MR/DD recipients, there was no evidence on the psychological exam that the recipient had a primary diagnosis of mental retardation prior to age 18 as required by chapter one of the *Operations Manual for Community Providers*. Physical exams and psychological exams are required by the *Operations Manual for Community Providers* as evidence of waiver eligibility for individuals in the HCBS MR/DD Waiver.
- The physical and/or psychological exams were not signed within the required time frame. The *Operations Manual for Community Providers*, chapter 1 requires that the psychological and physical exams must be performed within the preceding 12 months. If an exam was performed over 90 days but less than 1 year before entry into the waiver, it must be updated.

In our review of the service authorization process, testwork revealed that the service plans for 48 of 60 claims tested (80%) were improper. Problems with the service plans included the following discrepancies:

- There were no signatures on the service plans to indicate review.
- The service plans were not reviewed timely before the services were provided.
- The service plans were not on file at the regional offices; therefore, there was no evidence of any review prior to services being rendered.

Support plans serve as a planning tool to identify wants, desires, and goals of a recipient as well as the waiver services needed to achieve these wants, desires, and goals. The services identified in the support plan are used later in the preparation of the service plan. For 4 of 53 claims (8%) the ISPs were either missing, unsigned, or did not indicate a need for the services provided. The *Operations Manual for Community Providers*, chapter 2 requires the preparation of the support plan and a formal review.

Section 13 of the HCBS Waiver states that services under the waiver will be furnished pursuant to an approved plan of care (service plan). Documentation for approval of the service plan is based on appendix E of the HCBS MR/DD Waiver. Furthermore, the *Operations Manual for Community Providers* in chapter 2 states, "All services funded through the Medicaid Waiver . . . must be pre-authorized by DMRS Regional Offices." The manual also states, "The Service Plan must be submitted to the Regional Office at least one month prior to the person's most recent Service Plan authorization date."

We also examined cost plans as evidence of the preauthorization of waiver services. The cost plans are developed in conjunction with the service plans for each eligible waiver recipient. The cost plans identify the appropriate costs associated with the authorized services provided to eligible waiver recipients.

Testwork revealed that 50 of 53 claims (94%) for HCBS MR/DD Waiver recipients were not proper because of one or more of the following deficiencies:

- The cost plans were not signed to indicate review.
- The review and authorization of services were not performed timely.
- The cost plans were not on file.
- The authorized dates for service on the cost plan did not agree with those on the service plan.

A memorandum to Medicaid Waiver Providers from Mental Retardation Services requires that effective December 1, 1998, "All services must be authorized in advance, and in writing by the Regional Office, using a valid Cost Plan." Furthermore, a recent Compliance Review conducted by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, during the year ended June 30, 2001, noted, "The effective dates of the plans [Cost Plan and Service Plan] differed and could not be correlated with the data in the plans. . . . [R]egarding late service plans/cost plans . . . [i]n a recent query done by our office, it was noted that three individuals had plans that had expired. . . . Technically, these individuals are no longer in the waiver program."

In addition, we examined the recertifications for all waiver recipients. It was determined that for 2 of 60 claims (3%) there was no recertification on file. All the waivers require recipients to be recertified at least every 12 months.

We also performed testwork to determine if the waiver claims were adequately supported. For 19 of 53 claims for HCBS MR/DD recipients tested (35%), the problems noted included a lack of supporting documentation, documentation that did not agree with the services billed, and/or calculation errors of hours the service was provided in the documentation. For 4 of 7 claims (57%) for recipients enrolled in the Elderly and Disabled Waiver, the problems included claims where the support did not agree with the services billed, and/or calculation errors in the support.

We also examined the appropriateness of waiver rates. Testwork revealed that for 53 of 60 claims (88%), DMRS paid providers based on inappropriate rates. The 53 claims were paid based upon the rates in DMRS' Community Services Tracking System. However, these rates do not agree with the waiver-approved rates in the TennCare Management Information System (TCMIS) (see finding 21 for further details on this matter).

Finally, we examined claims for independent support coordination. Independent support coordination is provided to waiver recipients to assist them in obtaining services that are appropriate to their needs. Testwork revealed that for 4 of 37 claims tested for independent support coordination (11%), the independent support coordinator (ISC) did not maintain service plans or the service plan was not proper. The *Operations Manual for Community Providers*, chapter 3, requires an ISC to complete the service plan and submit it to the regional office.

The total amount of the 60 claims sampled and discussed in this finding were $110,230.80. Errors totaled $107,238.92 of which $68,222.72 is federal questioned costs. The remainder of $39,016.20 is state matching funds. The total amount paid for HCBS waiver claims was $171,982,027.21.

During the testwork, we also discovered that TennCare paid many claims in error to Senior Services, a provider of services for the elderly. Testwork revealed that DMRS paid for 127 "Minor Home Modifications" through the American Disabled for Attendant Programs Today (ADAPT) waiver for Davidson County when in fact Senior Services had not billed for minor home modifications. A total of $11,254.74 was paid to Senior Services because of the payment error for the 127 home modifications. Of this amount, $7,159.98 is federal questioned costs. The remaining $4,094.76 is state matching funds.

This testwork also revealed that one individual was approved to receive services under two different waivers, the Elderly and Disabled Waiver and the HCBS MR/DD Waiver. On the service plan for the MR/DD Waiver, independent support coordination services were approved for the period January 1, 2001, through February 28, 2001, and in the physician's plan for care in the elderly waiver, case management services were approved for the period December 22, 2000, through March 22, 2001. Although no duplicate payments were found, this individual was given the authorization to obtain similar services at the same time under two different waivers. Allowing individuals to be in multiple waivers could prevent others who need waiver services from obtaining access to the services because there is a limited number of slots available.

Since TennCare has not ensured that adequate processes were in place for the approval of recipient eligibility and for the review and payment of services under the Medicaid Home and Community Based Services Waiver, Medicaid providers of HCBS Waiver services were paid for ineligible recipients and inadequately documented services. The Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, requires that costs be adequately documented.

Recommendation

The Director of TennCare should determine why the measures taken in 2000 were inadequate and should ensure that the eligibility criteria for all individuals are documented on the PAE. The Deputy Commissioner over DMRS should ensure that review and approval of services under the HCBS Waiver is adequately documented in all support plans, service plans, and cost plans. In addition, cost plan and service plan dates should be in agreement. The Director should ensure that all individuals are recertified at least every 12 months. Waiver claims without adequate documentation should be denied. The Director of TennCare should ensure claims are paid in accordance with the waiver at the approved rates. The Director should ensure that ISCs maintain proper service plans. Payments for minor home modifications should be made only when the modifications are actually performed and documented on the claims form. The overpayments made for minor home modifications should be recovered. The Director of TennCare should ensure that recipients are approved for only one waiver so as not to limit access to services by others.

Management's Comment

We partially concur.

PAEs: PAEs are not approved by TDLTC without signatures and appropriate physicals and psychologicals for those applying for the MR waiver. It is reasonable to expect that an occasional human error could occur, but DTLC staff are very attentive to ensuring inclusion of the required elements prior to approving the forms. It is possible that supporting documentation could be detached from the original PAE form. We will review the PAEs in question and take appropriate action as necessary.

Update signatures: TDLTC policy is to consider the physician's signature on the PAE as an update to the physical and psychological examinations. We will review the records in question and take appropriate action as necessary.

ISPs: We concur that there continue to be problems with service and cost plans. DMRS is no longer distributing cost plans. Service plans are the mechanism used to authorize services. We are currently working with DMRS and waiver providers to streamline and improve the ISP format and service plan authorization process. A post-payment review process that includes evaluation of a sample of ISPs and service plans is included in this improvement effort.

Reviewers will look for corresponding dates on the ISP and service plan, signature authorization of the service plan prior to delivery of services, billing in accordance with hours of service provided and timeliness of updating and authorizing service plans and annual recertification. In addition, reviewers doing post-payment reviews and other QM surveys and targeted reviews will evaluate the appropriateness of the ISP to individual need. TDLTC and DMRS will collaborate in developing resolution to any deficiencies noted.

Individual enrollment in two waiver programs: Senior Services has been informed that it is inappropriate for a person to be enrolled in two waivers simultaneously. DMRS will be asked to send an information bulletin to all Support Coordination Agencies including the same clarification. In addition, the issue of simultaneous enrollment in two waivers will be addressed at March regional provider meetings. TDLTC will discuss with TennCare Information Systems staff any billing edits that can be done to prevent this from occurring in the future. Funding provided for services provided will be recouped from one of the waiver programs.

Rebuttal

It is not clear from management's comment with which part(s) of the finding management does not concur. Management has concurred with this audit finding in the previous two audits. Management did not address the part of the recommendation concerning minor home modifications.

24. TennCare's monitoring of the payments for the pharmacy program needs improvement, and TennCare needs to maintain annual drug use review reports

Finding

TennCare's monitoring of the payments for the pharmacy program needs improvement. TennCare contracts with Consultec, LLC (Consultec), to pay claims on a fee-for-service basis to providers for individuals who are both Medicare and Medicaid eligible as well as for behavioral health drugs for TennCare enrollees. Consultec pays the claims submitted by the pharmacy program providers, and then TennCare reimburses Consultec for the cost of the claims paid.

Discussions with management at TennCare revealed that TennCare has not adequately monitored the payments to Consultec. Some examples of the deficiencies in TennCare's monitoring of the contract between TennCare and Consultec include the following:

- TennCare did not monitor to ensure the amount paid to the providers for the drugs was correct.
- TennCare did not monitor to ensure that an individual provider claim was not reimbursed more than once.

- TennCare did not monitor to ensure that Consultec paid only providers for claims for TennCare eligibles who should be receiving benefits through Consultec.
- TennCare did not monitor to ensure that Consultec paid the providers the same amounts billed to TennCare.

Each week Consultec sends an invoice and a listing of the claims paid to the Bureau of TennCare's Fiscal Office. We examined the listings submitted by Consultec and determined that TennCare did not have a listing for 6 of the 52 weeks (11.5%) during the audit period. *Office of Management and Budget Circular A-87* requires that all costs are adequately documented. The total amount paid for these six weeks was $56,427,579, of which $35,897,815 is federal questioned costs. The remaining $20,529,764 is state matching funds.

Testwork on the other 46 weeks also revealed that 4 of the 64 claims selected (6%) did not have a complete date of service. These claims were missing a day or month. The total cost of the 64 claims sampled was $2,639.58. Because we were not able to determine the date the enrollee received the drugs, we were not able to determine if the enrollee was eligible on the dates in question. For the 60 claims with complete dates, 2 (3%) were not eligible for TennCare on the dates of service, according to the TennCare Management Information System. The amount TennCare reimbursed Consultec was approximately $614 million for the year ended June 30, 2001. The total amount paid for the six claims in question was $147.06. Federal questioned costs total $93.56. An additional $53.50 of state matching funds was related to the questioned costs. We believe likely questioned costs exceed $10,000 for this condition.

This inadequate monitoring could lead to duplicate paid claims, ineligible recipients receiving benefits, Consultec's not paying providers what is billed to TennCare, and/or the incorrect amount being paid for drugs.

In addition, the Social Security Act 1927 (g) (3) (A) through (D) requires that each state must establish a drug use review (DUR) board. The state must require that the DUR Board prepare an annual report that includes a description of the activities of the Board. The Director of Pharmacy said that TennCare submitted the annual report in December 2000. However, management could not locate the report that was sent.

Recommendation

The Director of TennCare should ensure that staff perform adequate monitoring of pharmacy program contract payments and develop and implement written policies and procedures as necessary to effectively monitor the contract with Consultec. All weekly listings of claims paid should be maintained and used to monitor the claims paid by Consultec. The monitoring effort should include procedures to ensure that claims are paid only for individuals who should be receiving benefits thorough Consultec, correct amounts are paid for drugs, no duplicate claims are paid, and Consultec is paying providers all the money transferred by TennCare. The Director should ensure that the annual DUR reports are kept.

Management's Comment

We do not concur with the questioned costs related to this finding since our review indicated that invoices were on file to support all amounts paid to the contractor. For two of the invoices, listings of claims that accompany the invoices were not on file. TennCare has requested the contractor provide these listings immediately. Upon receipt each week, the Bureau will perform the reconciliation that is normally done for these invoices to ensure that listings accompany all invoices.

We do concur with the need for monitoring procedures. The Bureau will coordinate efforts between the Fiscal Unit and the Pharmacy Unit to assure written policies and procedures are developed and followed to effectively monitor the contract between TennCare and Consultec (ACS). The monitoring effort will include procedures that will assure claims are paid correctly for eligible members and that Consultec pays providers exactly as they invoice the TennCare Bureau.

The 2000 annual DUR report was located when the responsible employee returned from medical leave. However, new policies and procedures will also address the writing and storage of the annual DUR report to ensure it is available to all necessary staff.

Rebuttal

OMB Circular A-133 defines a questioned cost as "a cost that is questioned by the auditor because of an audit finding. . . . Where the costs, at the time of the audit, are not supported by adequate documentation." Adequate documentation includes having the listings of individuals that Consultec has paid for at the time of audit. By not receiving or maintaining these listings, TennCare cannot ensure that payments to Consultec are for valid costs.

Management did not address the following concerns in their comments:

- claims with incomplete dates of service, and
- claims paid for individuals that were not eligible on the date of service.

25. TennCare paid capitation payments and fee-for-service payments on behalf of incarcerated enrollees, resulting in federal questioned costs of $4,278,607

Finding

As noted in the two prior audits, TennCare still has not ensured that when enrollees become incarcerated, adequate controls are in place to prevent capitation payments to managed care organizations and payments to providers for fee-for-service claims. In addition, TennCare still does not have a process to retroactively recover all capitation payments from the managed

care organizations (MCOs) when enrollees are incarcerated. Management concurred in part with the prior audit finding and stated that TennCare is working with the Department of Correction and the Program Integrity Unit of the Department of Finance and Administration, Office of Health Services, to improve information sharing. However, from the beginning of the audit period until February 2001, because of the temporary restraining order, TennCare did not terminate any incarcerated enrollees (see finding 8 for details). In February 2001, TennCare performed a data match with the Department of Correction's information to identify the prisoners on TennCare, which resulted in TennCare mailing 481 termination notices to enrollees. However, although TennCare mailed the termination notices, it continues to pay capitation payments for incarcerated enrollees. Management further responded to the previous audit finding that, in its opinion, the contracts with the MCOs should not be amended to permit retroactive recovery of payments for incarcerated enrollees.

Capitation payments are made to the MCOs and behavioral health organizations (BHOs) on behalf of TennCare enrollees to cover medical and mental health services. These payments are generated electronically each month by the TennCare Management Information System (TCMIS) based upon the recipient eligibility information contained in the system. If the eligibility information in TCMIS is not updated timely, then erroneous payments will be made. The fee-for-service claims are for payments that were made to providers for services or medical equipment provided to TennCare enrollees.

TennCare personnel stated that data received from the Tennessee Department of Correction is often incomplete and/or inaccurate. Prisoners are often not willing to give complete and/or accurate information regarding their identity (name, social security number, date of birth, etc.). These problems can often cause delays in identifying prisoners and stopping benefits.

Using computer-assisted audit techniques, a search of TennCare's paid claims tapes revealed that TennCare made payments totaling $6,725,519 from July 1, 2000, through June 30, 2001, for approximately 5,400 adult inmates in state prisons. Of this amount, $6,626,578 was paid to MCOs, and $98,941 was paid to providers for fee-for-service claims. Of these amounts, $4,278,607 is federal questioned costs. An additional $2,446,912 of state matching funds was related to the federal questioned costs.

Per the *Code of Federal Regulations*, Title 42, Part 435, Sections 1008 and 1009, the state, not the federal government, is responsible for the health care costs of adult inmates.

Based on discussions with TennCare's Information Systems staff, management's current policies still do not always prevent capitation payments from being made when enrollees are incarcerated and do not allow for recovery of capitation payments made for incarcerated adults. The policies include

- Management's policy decision not to disenroll any SSI (Supplemental Security Income) enrollees, including those that are incarcerated, until notification of death or proof that the individual has elected Medicaid coverage in another state. Testwork

revealed that many of the incarcerated individuals noted in fact were not classified as SSI enrollees in TennCare's System. (See finding 10 for more details.) This situation was communicated to management during the last audit, but management has failed to address it.

- The inclusion of Section 2-7(c) of TennCare's contracts with the MCOs prevents TennCare from making disenrollment retroactive "except for situations involving enrollment obtained by fraudulent applications or death." For example, if a person was incarcerated in June 2000 and TennCare was notified in September 2000, TennCare would only recover capitation payments made beginning September 2000, rather than going back to the exact date of incarceration in June.
- In May 2000, TennCare was placed under a temporary restraining order that prohibited TennCare from terminating or interrupting TennCare coverage for uninsured or uninsurable enrollees unless the enrollee has been afforded notice and an opportunity for a hearing in compliance with 42 CFR 431 E. In light of this order, TennCare did not rely upon its reverification process as a basis to terminate an individual. (See finding 8 for more information.) In October 2000, the Bureau was given authorization to terminate incarcerated adults in State Prisons. However, the prisoner match did not occur until February 2001, and the matched prisoners were not terminated until late in the audit period.
- Management's current policies do not include a data match to prevent or detect fee-for-service claims that were used to pay for incarcerated adults. The fee-for-service claims are paid based on the eligibility reported on TCMIS. If the eligibility information in TCMIS is not updated timely, then erroneous fee-for-service payments will be made.

Recommendation

Under the leadership of the Director of TennCare, management should determine which payments made on behalf of incarcerated adults can legally be recovered and take the necessary steps to recover all such payments. The Director of TennCare should ensure that the methodology used to detect incarcerated adults and to prevent or recover future capitation payments for adult inmates ensures compliance with federal regulations. Also, the methodology used should include procedures to prevent or recover fee-for-service payments made to providers for adult inmates. As management has chosen not to make changes in the MCO contract language that would allow full recovery of capitation payments for incarcerated enrollees, TennCare should develop a mechanism to identify these payments and use state dollars only to pay for these ineligible enrollees.

Management's Comment

We concur in part. We agree that a timely identification of incarcerated enrollees is important. We have been working with the Program Integrity Unit to improve a process of data

matching in order to identify possible incarcerated enrollees and will continue to work with them to refine those processes. We believe the amounts paid for incarcerated enrollees during the period of the TRO are allowable costs for federal reimbursement because they were due to federal court actions. We will review our controls over fee-for-service claims related to this issue and make adjustments that are cost effective. Further review of the auditor's testwork would assist in this.

Rebuttal

As stated in the finding, per the *Code of Federal Regulations*, Title 42, Part 435, Sections 1008 and 1009, the state, not the federal government, is responsible for the health care costs of adult inmates.

OMB Circular A-133 defines a questioned cost as a cost which "resulted from a violation or possible violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of Federal funds, including funds used to match Federal funds." TennCare should not pass on costs to the federal government when it has failed to establish adequate due process procedures resulting in a court order. If TennCare had adequate due process procedures in place, the court would not have issued the court order. See finding 8 for further details regarding this matter.

26. TennCare allowed providers to submit old claims and did not pay provider claims in a timely manner

Finding

As noted in the prior audit, the Bureau of TennCare allowed providers to submit claims later than 12 months from the date of service. In addition, the Bureau did not pay Medicare crossover provider claims within 6 months after receiving the Medicare claim. Management did not concur with the prior audit finding stating that it needed to review the claims in question to determine the reasons for the delay and that processing can appropriately occur outside of the timelines listed for a variety of reasons. But they stated that they would review their policies for this area and ensure they are appropriate. However, testwork revealed that the problems still exist.

The *Code of Federal Regulations* (CFR), Title 42, Part 447, Section 45(d), "Timely processing of claims," states,

> (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service. . . . (4) The agency must pay all claims [received] within 12 months of the date of receipt, except in the following circumstances: (i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system. . . .

> (ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim. (iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse. (iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, correction action, or other court order to others in the same situation as those directly affected by it.

The Bureau of TennCare pays Medicare crossover providers directly. The Division of Mental Retardation Services (DMRS) within the Department of Finance and Administration pays providers under the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS-MR) waiver. Department of Children's Services (Children's Services) providers are paid directly by Children's Services. After paying their providers, DMRS and Children's Services submit their provider claims to the Bureau for reimbursement.

Testwork revealed that TennCare paid $3,559,560 in claims to Children's Services and $2,819,304 in claims to DMRS for claims submitted after 12 months from the date of service. In addition, TennCare paid $31,390 in claims to crossover providers that were not paid within 6 months of receipt of the claim. Although federal regulations allow certain exceptions beyond the 12-month or 6-month requirement, the claims in question do not fall within the exceptions listed in the CFR.

The Bureau has system edits within the TennCare Management Information System (TCMIS) that appropriately prevent the payment of claims filed 12 months after the service dates for Children's Services, DMRS, and Medicare crossover provider claims, consistent with federal regulations. However, according to TennCare staff, personnel knowingly override these edits for Children's Services and Medicare crossover provider claims. In addition, TennCare does not use the system edit necessary to prevent payments of claims filed untimely from DMRS.

When claims are not received in a timely manner, the computer edits could be utilized to halt payments to Children's Services, DMRS, and Medicare crossover providers. By not using edits and overriding edits, TennCare cannot ensure that these claims are denied as required, and TennCare enables the state departments to continue to defy federal regulations without consequences. When claims are received in a timely manner, late processing of claims by the Bureau could result in use of state funds for payment of the old claims, without federal participation.

Recommendation

The Director of TennCare should ensure that HCBS-MR waiver and Children's Services claims are received within 12 months of the date of service and that Medicare crossover provider claims are paid within 6 months after receiving notice of the disposition of the Medicare claim.

The Director should ensure that the system edit within TCMIS for the timely filing of claims is used and not overridden.

Management's Comment

We concur. We have implemented edits to prevent payment of claims submitted over twelve months after the service date. We are reviewing the controls over cross-over claims and will implement necessary changes to ensure compliance with regulations.

27. TennCare did not recover fee-for-service claims paid to providers and used federal matching funds for capitation payments paid to managed care organizations for deceased individuals including those who had been dead for more than a year

Finding

As noted in the prior three audits, TennCare has not ensured that adequate controls are in place to recover fee-for-service payments that are made to providers for dates of service after an enrollee's date of death. In addition, TennCare has claimed federal matching funds for capitation payments paid to managed care organizations for deceased individuals who have been dead for more than a year. Management partially concurred and stated that procedures over recovery of fee-for-service claims paid on behalf of deceased enrollees would be reviewed. However, no changes were made to the procedures.

Management did not concur with the finding related to recoveries of capitation payments for enrollees prior to 12 months before the date-of-death notification because they "believe the contract with the MCOs does not permit retroactive recovery of capitation payments for enrollees greater than twelve months." In February 2002 management obtained an opinion from the Attorney General's office on the recovery of capitation payments. The opinion states "this Office believes that retroactives adjustments greater than 12 months for deceased TennCare enrollees should not be made for period prior to July 1, 2001." Although the contract would prohibit the recovery of payments from the MCOs for these indivduals, TennCare has continued to claim federal financial participation for individuals that have been deceased for more than 12 months. For costs to be allowable for federal financial participation, the costs must be paid for allowable servicies provided to living enrollees.

The capitation payments are made to the MCOs on behalf of TennCare enrollees to cover medical services. These payments are generated electronically each month by the TennCare Management Information System (TCMIS) based upon the recipient eligibility information contained in the system. If the eligibility information in TCMIS is not updated timely, then erroneous capitation and fee-for-service payments will be made. According to TennCare staff, often there can be delays in obtaining information about deceased individuals. Thus, it is important to retroactively recover payments when there is a delay in the death notification.

TCMIS is currently set up to recover payments retroactively to only 12 months before the date-of-death notification. Although TennCare does not always receive notification of date-of-death in a timely manner, timely reverification of eligibility would allow TennCare to detect a change in an individual's eligibility status. However, because of a Temporary Restraining Order TennCare has not reverified the eligibility of enrollees timely (see finding 8 for more details).

When it takes over a year to detect an enrollee's death, TennCare does not recover all of the fee-for-service payments made for deceased individuals and, although the MCO contracts prohibit recovery of capitation payments for indivdiduals who have been deceased for more than a year, TennCare has claimed federal matching funds for these individuals. We performed a data match between capitation payments per TennCare's paid claims tapes and date-of-death information from the Office of Vital Records in the Department of Health. We found that TennCare paid $550,696 to the MCOs on behalf of deceased individuals reported by the Office of Vital Records. We selected a sample of 60 of these payments to the MCOs totaling $9,752 to determine if these payments had been recovered. For 3 of 60 MCO capitation payments tested (5%) totaling $839, TennCare had not recovered the payment to the MCOs as of November 28, 2001. Further follow-up of these payments revealed that these three payments had not been recovered because of the 12-month limitation. These individuals were deceased prior to the dates of service, and TennCare has used federal matching funds for the payments made on behalf of these deceased individuals.

Federal questioned costs totaled $534. The remaining $305 was state matching funds. We believe that likely federal questioned costs associated with this condition could exceed $10,000.

We also performed a computer-assisted audit technique (CAAT) to compare capitation payments per TennCare's paid claims tapes with TennCare's own eligibility history files. The search revealed that TennCare made payments totaling $169,427 to the MCOs from July 1, 2000, through June 30, 2001, for which the date of death recorded in TCMIS was before the dates of service. Testwork was performed for a sample of the 60 payments to the MCOs to verify that these payments had been recovered. Testwork revealed that all the payments had been properly voided or adjusted.

The fee-for-service payments are for services or medical equipment provided to TennCare enrollees. The fee-for-service claims are paid or denied based on recipient eligibility information listed in TCMIS. Based on discussion with management, the fee-for-service payments occurred because the date-of-death notification occurred after the date of the payment. For example, if an individual were to die on January 1, 2000, and TennCare paid for the use of durable medical equipment after the date of death but before it received a date-of-death notification, TennCare would be required to recover the payment. Although exception reports are produced that alert management of these recipients, discussion with management revealed that the reports produced by the system do not include all the recipients. According to Information Systems staff, the recoveries for fee-for-service claims are performed manually, not automatically by the system. Not using TCMIS to automatically recover these payments increases the risk that payments might

not be recovered. In addition, management stated that if more than a year were to pass before one of these payments were to be identified, then a recovery would never be made.

In the data match between fee-for-service payments and date of death information in TCMIS we found payments totaling $241,458 for which the dates of death recorded in TCMIS were before the dates of service. Testwork was performed on a sample of 71 of these fee-for-service transactions totaling $21,287 to verify that these payments had been recovered. For 53 of 71 fee-for-service payments tested (75%), TennCare had not recovered the payment as of November 14, 2001. A total of $8,939 was paid and not recovered for the dates of service that were after these individuals' dates of death in TCMIS. Federal questioned costs totaled $5,687. The remaining $3,252 was state matching funds.

We also performed a data match between fee-for-service payments per TennCare's paid claims tapes and date-of-death information from the Office of Vital Records. We found that TennCare paid $43,316 in fee-for-service claims on behalf of deceased individuals, based on information from the Office of Vital Records. Testwork was performed on a sample of 25 of the fee-for-service payments totaling $4,428 to determine if these payments had been recovered. For 11 of 25 payments tested (44%), totaling $1,485, TennCare had not recovered the payment as of September 18, 2001. Further follow-up of these payments revealed that four of these payments had not been recovered because of the 12-month limitation. The other seven payments had not been recovered because the individual had not been listed on the TCMIS reports used to recover fee-for-service payments. Federal questioned costs totaled $945. The remaining $540 was state matching funds. We believe likely question costs could exceed $10,000.

Recommendation

The Director of TennCare and TennCare management should develop and implement effective controls to recover payments for individuals when the date-of-death notification occurs after the date of payment. In addition, the Director of TennCare should ensure that all fee-for-service payments made on behalf of deceased recipients are recovered back to the date of death. The Director should ensure that capitation payments made beyond the 12-month limitation are not funded with federal matching dollars. If management believes that these costs for deceased enrollees can be paid with federal matching dollars, written clarification regarding this situation should be obtained from the federal grantor.

Management's Comment

We do not concur. Procedures are in place to identify fee-for-service payments to deceased enrollees and to recover those payments when date of death notification occurs after the date of payment. However, the Bureau will review the cases cited by the auditors to ensure that procedures in place are effective.

Rebuttal

As stated in the audit finding, we found fee-for-service payments on behalf of deceased enrollees. Since we found these payments it is clear that the procedures in place for fee-for-service payments were not effective and need improvement.

Management did not address the part of the recommendation concerning capitation payments.

28. Against the direction of the Centers for Medicare and Medicaid Services, TennCare inappropriately claimed federal matching funds for premium taxes related to the graduate medical education program and a pool payment made to Meharry Medical College

Finding

Against the direction of the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), TennCare inappropriately claimed federal funds for premium taxes related to the graduate medical education program and a pool payment to Meharry Medical College for their dental program.

TennCare has contracted with four graduate medical schools to administer the graduate medical education program. For the year ending June 30, 2001, these contracts with the schools totaled $46 million.

In addition to these four contracts, TennCare also contracted with Volunteer State Health Plan (VSHP), a Managed Care Organization (MCO), to disburse the $46 million to the four graduate medical schools. However, TennCare's payments to the VSHP resulted in MCO premium taxes that were to be paid by the VSHP back to the state. As a result, TennCare contracted with VSHP for a total of $46,938,776 to cover the VSHP's premium tax cost. The approval letter from CMS to TennCare for the graduate medical education program specifically states,

> . . . as we have already advised your staff, the State cannot claim Federal financial participation (FFP) for the $938,776 that you intend to pay Volunteer State Health Plan for their cost of the MCO premium tax that will be paid back to the state.

An examination of TennCare's quarterly expenditure report revealed that TennCare claimed federal financial participation for this premium tax. The premium tax totaled $938,778, of which $598,846 is federal questioned costs. The remaining $339,932 is state matching funds.

TennCare also contracted with Xantus Healthplan to make a pool payment to Meharry Medical College for Meharry's dental program. The total amount paid to Xantus was $4,909,168, which consisted of the payment to Meharry of $4,810,005, a 2% MCO premium tax of $98,163, and an administrative fee to Xantus of $1,000.00. The CMS approval letter for this pool payment also prohibited TennCare's claiming the federal financial participation on the payment to Xantus for premium taxes. However, TennCare claimed $62,618 in federal financial participation for the premium tax, which is federal questioned costs. The remaining $35,545 is state matching funds.

TennCare's failure to follow specific CMS guidance outlined in the approval document has resulted in federal questioned costs and could also jeopardize future federal funding.

Recommendation

The Director of TennCare should ensure that TennCare follows directives of the federal grantor in determining which costs can be funded with federal dollars.

Management's Comment

We do not concur. It is our opinion that these are allowable expenditures under Title XIX regulations. It is our responsibility to claim all expenditures eligible for federal funding. CMS officials are aware the state claimed the funding and we have not received any further correspondence from CMS on this issue.

Rebuttal

CMS specifically states in the approval letter that TennCare cannot claim federal financial participation for these taxes. CMS, not TennCare, is ultimately the judge as to which costs are allowable and which costs are not. OMB Circular A-133 defines a questioned cost as a cost which "resulted from a violation or possible violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of Federal funds, including funds used to match Federal funds" [emphasis added].

29. TennCare did not approve contracts related to the graduate medical education program before the beginning of the contract period

Finding

The Bureau of TennCare did not ensure that the contracts with the four graduate medical schools were approved before the contract period began. Chapter 0620-3-3-.04(c)(8) of the *Rules of the Department of Finance and Administration* states that "upon approval by the Commissioner of Finance and Administration it [the contract] shall be an effective and binding contract." A contract should serve as the legal instrument governing the activities of TennCare as they relate to the graduate medical schools and should specify the scope of services, grant terms, payment terms, and other conditions. According to TennCare personnel, there were many discussions with the Centers for Medicare and Medicaid Services formally known as the Health Care Financing Administration (HCFA) regarding the payments to the medical schools and the contracts. These discussions delayed final approval of the contract.

The contracts between the Bureau and Meharry Medical College, East Tennessee State University, and the University of Tennessee at Martin with a beginning effective date of July 1, 2000, were approved on June 21, 2001, over 11 months after the beginning effective date. The contract with Vanderbilt University with a beginning effective date of July 1, 2000, was signed on July 9, 2001, over a year after the beginning effective date.

The Bureau contracted with an MCO, Volunteer State Health Plan (VSHP), to make the payments to the graduate medical schools. Discussion with staff at the medical schools revealed that Vanderbilt University and East Tennessee State University received payments from VSHP before TennCare had contracts with the schools that were signed by all the necessary parties. Vanderbilt University received a $12,568,014 payment on June 21, 2001, 18 days before there was an approved contract. East Tennessee State University received an $8,576,612 payment on June 20, 2001, one day before there was an approved contract. The total amount paid to all four medical schools for the primary care component was approximately $46 million. In addition, the Bureau of TennCare made payments directly to all four of the graduate medical schools totaling $33,750 throughout the year for the stipend component of the graduate medical education program before the contracts were approved.

Not having an executed contract in place at the beginning of the contract term can lead to confusion between the parties regarding the scope of services, grant terms, payment terms, and other conditions. In addition, if contracts are not approved before the contract period begins and before services are rendered, the state could be obligated to pay for unauthorized services.

Recommendation

The Director of the Bureau of TennCare should ensure that all contracts are signed before the effective date and payments are not made to contractors before approved contracts are in place.

Management's Comment

We concur in part. Contract approval was delayed pending CMS approval of the program. CMS required the state to alter the program. The schools had to receive the funding from a managed care organization rather than directly from the state. This was not approved until June of 2001. The stipend payments made were part of stipend agreements already in place prior to fiscal year 2001 and therefore the state was committed to these items. We agree that the agreements should have been signed before funds were disbursed. This was an oversight and the contracts were signed within 18 days of the disbursement.

Auditor's Comment

It is not clear from management's comment with which part(s) of the finding management does not concur. Management is responsible for having contracts approved before they are effective. If there are anticipated delays in getting contracts approved, then management should start the contract approval process earlier to ensure timely approval of the contracts.

30. TennCare continues to disregard its own rules regarding overpayments to providers and needs to improve processing of Medicare cross-over claims

Finding

As noted in the five prior audits, TennCare has not complied with departmental rules, resulting in overpayments to providers for Medicare cross-over claims (claims paid partially by both Medicare and Medicaid). Furthermore, as noted in the prior four audits, TennCare has not corrected control weaknesses in processing the Medicare cross-over claims.

Medicare recipients are required to pay coinsurance and a deductible to the provider for services received. If the patient is also eligible for Medicaid, Medicare bills TennCare instead of the patient for the coinsurance and deductible. According to the *Rules of the Tennessee Department of Finance and Administration*, Chapter 1200-13-1.05, in effect during the audit period, the total amount paid by all parties (Medicare, patient, and TennCare) cannot exceed the fee limitations set by TennCare. Management concurred with this portion of the prior-year audit finding and stated that "a rule was drafted which stated that the total amount paid by a combination of Medicaid as a deductible and coinsurance shall not exceed the amount Medicaid otherwise would have paid for the covered service, or, where there is no Medicaid fee schedule, reasonable billed charges." According to the Chief Financial Officer, in April 2001, TennCare proposed to change the rules. However, this rule did not become effective until November 4, 2001, after the audit period.

Although the old rule stated above was in effect during the audit period, TennCare's computer system always paid the entire deductible or coinsurance billed for outpatient hospitalization services, regardless of how much Medicare or the patient paid or any limitations

set by TennCare. In addition, the TennCare Management Information System (TCMIS) did not always ensure that claims from ambulance services, anesthesiologists, clinical psychologists, clinics/groups, and claims for durable medical equipment (DME) from other out-of-state providers complied with this rule. The total amount of all expenditures for professional and institutional cross-over claims during the year ended June 30, 2001, was approximately $76 million.

Testwork revealed that for 30 of 60 Medicare professional cross-over claims tested (50%), payments exceeded the maximum allowable. The 60 claims totaled $670.73, and $525.73, or 78%, was unallowable. TennCare's payments of $525.73 exceeded the maximum amount allowed according to the Medicaid Fee Schedule and the rule stated above. Federal questioned costs totaled $334.46. The remaining $191.27 consisted of state matching funds. During the year ended June 30, 2001, TennCare paid $49,667,034 for Medicare professional cross-over claims. We believe likely questioned costs associated with this condition exceed $10,000.

Although professional cross-over claims from psychologists and social workers have been Medicaid-eligible since the late 1980s, these claims are to be denied if the recipients have other insurance (third-party resources). In response to the prior-year audit, management stated that they would review the third-party liability issues surrounding cross-over claims noted; however, according to various personnel, this was not done during the audit period. OMB Circular A-133 requires that "states must have a system to identify medical services that are the legal obligation of third parties." However, TCMIS has not been updated to detect third-party resources on these cross-over claims.

TennCare's policies and procedures manual for pricing cross-over claims is not adequate. Our review of the pricing manual revealed that it does not contain sufficient detail to allow a relatively inexperienced individual to price cross-over claims. In addition, TennCare's policies and procedures manual discusses claim type 18 (Professional Crossover Claims), but does not discuss claim type 17 (Institutional Crossover Claims), nor does it include the pricing methodology for claim type 17.

During the testwork performed on professional cross-over claims, it was noted that the following pricing procedures are not discussed in TennCare's policies and procedures manual:

- For Durable Medical Equipment and Anesthesia claims, TennCare always pays the amount billed by Medicare.
- For certain procedure codes, the system automatically pays the rates loaded in the system.
- For claims with injection codes, the system automatically pays a $2.00 administrative fee.
- For claims where there is not a type of service listed, TennCare pays the amount which is billed.

Recommendation

The Director of TennCare should ensure that TCMIS has been updated to detect third-party resources on cross-over claims and should ensure that TennCare's policies and procedures regarding cross-over claims are adequate. The Director of TennCare and staff should ensure that the Bureau's policies, procedures, and computer systems are updated timely to reflect new developments.

Management's Comment

We do not concur that the TennCare system always paid the entire deductible or coinsurance billed for outpatient hospital services regardless of how much Medicare or the patient paid or any limitation set by TennCare. We currently pay the Medicare Hospital Part B deductible as billed; however payment for the Medicare Part B institutional cross-over claim is determined by reducing the allowable charges on an outpatient claim using a percentage established for each hospital. This percentage is maintained on the provider's master file (TPIQ). For each outpatient and inpatient Part B cross-over claim, the Medicare allowed amount minus any cash and/or blood deductible amounts will be multiplied by the hospital's established percentage to determine the allowable amount and Medicare payment. Medicaid will pay the difference between this allowable amount and the Medicare payment.

We do not concur that professional cross-over payments exceeded the maximum allowable. The TCMIS recalculates payments for most provider specialties but not the Medicaid Fee Schedules for the provider groups referenced in the audit finding.

We will review the claims tested by the auditors to determine if the current reimbursement logic for the Medicare Part B crossover claims will require any additional policy revisions.

We do not concur that there is no procedure to identify third-party liabilities (TPL). A manual procedure is in place to add or change TPL data as a result of reviewing a cross-over claim for TPL coverage. When claims are pended for TPL, the TPL information attached to the claim is compared to the TPL information in the TCMIS system. Any needed changes are made to the TennCare TPL history data from this process. The suspended claim for the TPL edit is overridden if the TPL information on the claim attachment validates that the TPL information within the TCMIS is no longer active or does not cover the cross-over claim service. Otherwise, the suspended claim is denied. If the information/claim attachment identifies additional TPL coverage, the coverage is added to the TCMIS. We are not aware of special cross-over claims which have been paid in error as a result of third-party information on file. TennCare, Information Systems management will review the auditor's testwork sampled for TPL to determine whether claims were paid in error.

We do not concur that the policies and procedures manual used in the Provider Relations unit does not discuss or include information on the pricing methodology for claim type 17

(Institutional Crossover Claims). The current manual has a copy of the Medicaid Hospital Bulletin dated September 1996, this bulletin details the reimbursement methodology used to price Medicare crossover claims for the Inpatient Hospital deductible. In addition, the manual has a copy of the Medicaid Hospital Bulletin dated June 1998, detailing the reimbursement methodology for pricing Medicare Outpatient cross-over claims.

We concur that the TennCare system reimburses the billed charges on claims without the type of service listed on the claim. We are currently working with IS to require EDS to return all claims received without the type of service indicator listed. Regarding reimbursement for the Medicare cross-over claims with injection codes, we will review claims tested by the auditors to determine if the reimbursement logic is within the current rules.

Rebuttal

This is the sixth consecutive year that there has been at least one finding in the audit concerning Medicare cross-over claims. Management concurred with this audit finding in each of the previous audits.

Regarding the comments about the deductibles and coinsurance, on numerous occasions we asked staff about the processes concerning these issues. The information presented in management's comments was not communicated to us until February 2002.

As noted in the finding, 30 of 60 claims did exceed the maximum allowable. The *Rules of the Tennessee Department of Finance and Administration*, Chapter 1200-13-1.05(3)(c), that was in effect during the audit period states:

> the total amount paid by a combination of Medicare for the covered health care services, patient liability, if any, and Medicaid as deductible and co-insurance shall not exceed the limit of the Medicaid fee schedule. . . .

To be in compliance with this rule, TennCare should have calculated the payments based upon the Medicaid Fee Schedule for all provider groups.

During fieldwork, we asked the Chief Financial Officer and the Director of Information Systems about any changes made to the system to detect third-party resources for these cross-over claims. Although the issue regarding claims for psychologists and social workers has been in the previous audit findings, both indicated that no changes had been made to TCMIS to detect third-party resources. While we agree that there are procedures to detect TPL on some claims, we did not state in the audit finding that "there is no procedure to identify third-party liabilities."

Management's comments do not address specifically how the system detects third-party resources on claims for psychologists and social workers.

The provider relations manual provided to us during fieldwork did not contain a Medicaid Hospital Bulletin dated September 1996, nor did it include a copy of a Medicaid Hospital Bulletin dated June 1998.

Management did not address the concerns in the finding regarding the following issues not being in the policies and procedures manual:

- For Durable Medical Equipment and Anesthesia claims, TennCare always pays the amount billed by Medicare.
- For certain procedure codes, the system automatically pays the rates loaded in the system.
- For claims with injection codes, the system automatically pays a $2.00 administrative fee.

31. TennCare made purchases from vendors that did not comply with federal regulations

Finding

TennCare made purchases from vendors that were not in compliance with the Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*. Circular A-87 basic guidelines require that purchases "conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items" and "be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit." The basic guidelines also require that all costs be adequately documented.

Testwork revealed that 10 of 45 purchases (22%) sampled did not comply with one or both of the basic guidelines because the purchases did not comply with state purchasing procedures. The causes of noncompliance were

- 7 of the 45 (15%) were not adequately documented and
- 8 of the 45 (18%) did not conform to all limitations required by the Delegated Purchase Authority (DPA) which TennCare used to make these purchases.

In addition, testwork revealed that 3 of the 45 authorizations to vendors (7%) were not mathematically accurate.

Of the seven purchases that were not adequately documented, the following deficiencies were noted:

- The "authorization to vendor" form used to make all purchases of these services was not signed by the vendor.
- The amount on the invoice from the vendor was lower than the amount actually paid.
- The time sheets of the vendors were not attached, making it impossible to determine compliance with the DPA limits discussed later in the finding.
- The supporting documentation did not include the cost center, allotment code, and DPA number.
- The hours on the vendor's invoice did not agree with the amounts on the vendor's time sheets.

DPAs are granted by the Commissioner of the Department of Finance and Administration to departments when purchases are small in nature and frequent in occurrence and it is not practical to determine in advance their volume, delivery, or exact costs. DPAs assist departments in expediting the purchasing process. Of the eight that did not conform to all limitations required by the DPA, these errors resulted because of one or both of the following reasons:

- The total purchase exceeded the $5,000 limit required by Section E of the DPA.
- The purchase included one or more of the vendor's employees, which exceeded the $250 per day limit required by Section F of the DPA.

The total known questioned cost associated with the above conditions is $48,890. Of the $48,890 paid, federal questioned costs are $24,445. An additional $24,445 of state matching funds was related to the federal questioned costs. The total amount paid for the sample of 45 purchases was $89,762. According to data from the State of Tennessee Accounting and Reporting System (STARS), the total amount paid pursuant to this DPA was $920,250. The failure to comply with these federal regulations indicates inadequate review was performed with regard to these costs, and future potential purchases could be unallowable.

Recommendation

The Chief Financial Officer (CFO) should ensure that all costs are in compliance with Circular A-87 guidelines. The CFO should ensure that adequate procedures to detect payments not in compliance with OMB Circular A-87 guidelines are performed during the payment review and approval process.

Management's Comment

TennCare concurs that all costs should be in compliance with Circular A-87 guidelines. TennCare will ensure that adequate procedures are in place to detect payments not in compliance with OMB Circular A-87 guidelines when performing payment review and approval processes.

However, we do not believe that these payments should be disallowed. Although we did not completely follow state purchasing guidelines, these expenditures were for allowable costs.

Specifically, the finding states that seven (7) were not adequately documented. The Direct Purchase Authority (DPA) contract states that a vendor authorization form should be used for billing purposes; however, the contract does not stipulate that supporting documentation must accompany the vendor authorization form. A vendor authorization form stipulates an amount invoiced to the state and requires the vendor's signature and further requires TennCare program staff approval on the services rendered (attesting that this is an approved authorization form for payment). TennCare attaches all supporting documentation to the vendor authorization form. Currently, TennCare accounts payable staff requires all vendor authorization forms to be accompanied with supporting documentation exceeding the terms stated in the contract.

Additionally three payments were not mathematically correct. In reviewing supporting documentation and the vendor authorization billing forms, mathematical errors were found. Some vendors are paid an hourly rate, and when supporting documentation (timesheets) stated x number of hours times the hourly rate and this differed from the amount stated on the vendor authorization form, then staff made every effort to correct any mathematical errors.

Further, several instances were found where payments exceeded specified payment rates/schedules as stated in the DPA contract. These payment rates/schedules were requested in the DPA contract and upon review, several of the payment rates were requested to be increased in the new approved DPA for the current fiscal year. Program staff were informed to make sure all vendor authorization forms adhere to the stipulated amounts (payment rates/schedules) in the contract.

32. TennCare did not require contractors and providers to make necessary disclosures concerning suspension and debarment

Finding

As noted in the prior audit, the Bureau of TennCare did not require all providers of goods and services with contracts with TennCare equal to or in excess of $100,000 and all others involved in nonprocurement transactions to certify that their organization and its principals are not suspended or debarred from a government program. Management concurred with the finding and stated that the Bureau would "ensure that contractors provide certifications related to suspension and debarment." However, the problem still exists. Management also stated that they would "work with the Division of Mental Retardation on compliance with this area."

However, TennCare still did not ensure that the Division of Mental Retardation changed its contracts for the audit period to require providers to certify that their organization and its principals are not suspended or debarred.

Testwork revealed that 21 of 30 contracts with nongovernmental entities (70%) did not include the suspension and debarment certification. Testwork also revealed that the Bureau's purchasing manual does not contain federal requirements concerning suspension and debarment.

According to the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations*, Title 45, Part 76,

> Non-federal entities are prohibited from contracting with or making subawards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods and services equal to or in excess of $100,000 and all nonprocurement transactions. . . . Contractors receiving individual awards for $100,000 or more and all subrecipients must certify that the organization and its principals are not suspended or debarred.

Because the Bureau does not always require contractors and providers to certify that their organization and its principals are not suspended or debarred, the Bureau would be less likely to know if it had contracted with suspended or debarred parties.

Recommendation

The Director of TennCare should require all providers of goods and services with contracts with TennCare equal to or in excess of $100,000 and all others involved in the nonprocurement transactions to certify in the contracts that their organization and its principals are not suspended or debarred from a government program. The purchasing manuals should be amended to include the federal requirements. In addition, the Director of TennCare should ensure that the Division of Mental Retardation requires its providers to certify that they have not been suspended or debarred.

Management's Comment

We concur in part. TennCare concurred with the auditors' finding for State Fiscal Year ending June 30, 2000. However, numerous contracts were already in place for FY 2000-2001 which did not have the needed language and are the reason for this repeated finding. Effective March 2001, with our new contract officer position filled, TennCare started inserting the suspension and debarment language manually in all new and/or amended contracts. The suspension and debarment language was not part of the standard language issued by the Department of Finance and Administration, Office of Contract Review. TennCare has included the language in contracts entered into for FY 2001-02. In addition, TennCare worked with the

Office of Contract Review and effective January 1, 2002, the suspension and debarment language was inserted as standard language in state contracts.

Further, TennCare worked with the Division of Mental Retardation Services (DMRS) and effective July 1, 2001, provider agreements now contain the suspension and debarment language.

Any purchase in excess of $100,000 made by TennCare's Purchasing Unit must be approved by the Department of General Services, Purchasing Division. The Department of General Services is the state agency responsible for the debarment of any vendor, as outlined in their *Agency Purchasing Procedures Manual*, Section 18.5, Removal from Qualified Vendor List.

TennCare's *Purchasing Policy and Procedures* manual contains *The Department of General Services' Agency Purchasing Procedures Manual*, which includes a section on suspension and debarment. Furthermore, the TennCare manual has been amended to add a section on vendor debarment.

Auditor's Comment

There is not a specific section in the *Department of General Services' Agency Purchasing Procedures Manual* that pertains to federal suspension or debarment requirements. Management's comment cites Section 18.5, "Removal from Qualified Vendor List," which pertains to vendors who have not responded to the state's Invitations to Bid and are subject to removal from the state's Qualified Vendor List. Vendors who are on the state's Qualified Vendor List may be suspended or debarred by the federal government. The Tennessee Department of General Services is not responsible for compliance with federal suspension and debarment requirements. Instead each department must ensure compliance.

In addition, review of TennCare's purchasing manual provided during fieldwork revealed that the federal suspension and debarment requirements were not included. If TennCare's purchasing manual addressed all federal suspension and debarment requirements that it needed, it is unclear why management in their comments state that TennCare's manual "has been amended to add a section on vendor debarment."

33. TennCare needs to improve internal control over premiums

Finding

As noted in the previous two audits in findings with which management concurred, testwork again revealed several discrepancies in the internal control over enrollee premiums receivable. Management concurred with both previous findings and stated in response to the most recent that "TennCare will review the current controls and procedures relative to premium reporting." However, testwork revealed the same weaknesses still exist.

Premiums are collected from enrollees who are classified as uninsured or uninsurable. These enrollees are required to pay premiums in order to receive health services under the program. TennCare is responsible for maintaining the enrollee's premium account and for determining the applicable monthly premium amount based on an enrollee's income and family size. Testwork revealed that TennCare still lacks internal control to ensure the accuracy of premium reporting:

- Testwork revealed that TennCare was not properly verifying and reverifying eligibility for the purpose of premiums (see finding 8 for more information). Therefore, proper premiums may not be charged to enrollees.
- The cumulative report provided to the auditors during this audit period contained differences from the reports used in each of the two prior audits. The TennCare Bureau prepares a cumulative premium report each month to track the total premiums billed to enrollees, the total amount remitted by enrollees, the total amount due from enrollees, and the total premium statements mailed to enrollees for each month. Management uses this report to develop premium estimates for financial reporting purposes. Our review of this cumulative report revealed several inconsistencies that jeopardize the reliability of this report. For example, the amount of premiums billed for the month of January 1994 was different on all the reports provided to auditors. Although the amount should not have changed, the report auditors received in 2001 showed January 1994 billings as $485,170, the 2000 report showed January 1994 billings as $485,444, the 1999 report showed $485,645, and the 1998 report showed $487,046. Such an inconsistency, while immaterial, shows that the report is unreliable. Management indicated that this difference was the result of computer programming errors.
- In addition, the column that summarizes total due from enrollees reported balances when, in fact, management had written off these receivable balances. These balances were included in the calculations of year-end premium receivables. Management indicated that this difference was the result of computer programming errors.
- There are inadequate written procedures for the comparison of the list of deposits prepared by Electronic Data Systems (EDS), the fiscal agent, with the State of Tennessee Accounting and Reporting System (STARS) transactions listings. For example, the procedures do not describe which reports should be compared and how to document this review. As a result, the comparison with the list of deposits is sometimes compared to a STARS transaction listing and sometimes it is compared to the Certificates of Deposits (CDs). Not having adequate written procedures results in a review that is not adequately and/or consistently documented.
- TennCare management does not perform analytical procedures on projected enrollee premium income on a month-to-month basis. By not performing such an analysis, TennCare would not be aware of fluctuations that could indicate inaccuracies in premium billings. For example, TennCare does not compare enrollment data to the total amount billed.

These weaknesses in internal control could cause inaccurate reporting of premium income to the federal grantor and in the State of Tennessee's Comprehensive Annual Financial Report, and inaccurate premium amounts being billed to enrollees.

Recommendation

The Director of TennCare should strengthen internal control over premiums for the uninsured and uninsurable enrollees. Internal control should include reliable premium reporting, analytical reviews, and proper verification and reverification of eligibility for premium determination.

Management's Comment

We concur in part.

Some of the changes in reports are due to changes in enrollee information over time between dates the reports are run. We do concur that we need a more definite explanation of the reasons for the various differences.

We concur that procedures over reconciling deposits by EDS and information in STARS should be documented. Staff have been directed to document our procedures. We are working diligently with EDS and Bureau staff to refine the various premium reports for the various reasons mentioned in the finding including enabling analytical procedures to be performed on billing information. These reports are currently in being produced and tested for validity. We currently perform some analytical procedures, but agree that it would be improved with enhanced reporting.

Auditor's Comment

It is not clear from management's comment with which part(s) of the finding management does not concur.

34. TennCare did not comply with the Department of Finance and Administration's Policy 22, Subrecipient Monitoring

Finding

The bureau did not identify and report its subrecipients to the Department of Finance and Administration (F&A) as required by Policy 22. Policy 22 establishes guidelines for uniform monitoring of subrecipients that receive state and/or federal funds from state departments, agencies, and commissions. The policy requires TennCare to submit an annual monitoring plan

to the Division of Resource Development and Support (RDS) in the Department of Finance and Administration for review, comment, and approval by September 30 of each year. This plan should identify all subrecipients to be monitored, describe the risk criteria utilized to select subrecipients for monitoring purposes, identify full-time equivalents dedicated to monitoring activities, and include a sample monitoring guide. TennCare has not prepared and submitted the required plan to identify its subrecipients and document other plan requirements for the audit period.

In addition, TennCare is required to submit an annual report summarizing its monitoring activities to the RDS by October 31 of each year. Per TennCare management, the report was not submitted to the division. According to management, this report was not submitted because action on other issues was a higher priority than submitting the report.

Not submitting the required monitoring plan and annual report resulted in inadequate monitoring of subrecipients.

Recommendation

The Director of TennCare should ensure that the required annual monitoring plan is submitted by September 30 of each year and that the plan includes all the required information. Also, the Director should ensure that the annual report summarizing TennCare's monitoring activities is submitted by October 31 of each year.

Management's Comment

We concur. However, we disagree with the auditor's comment that not submitting the required plan and annual report resulted in inadequate monitoring of subrecipients. During the audit period, each contract was assigned to an individual for monitoring purposes.

To ensure compliance with Policy 22, the Bureau has assigned an individual the responsibility for coordinating contract monitoring. A process has been implemented to evaluate each contract in accordance with Policy 22 to determine those that are subrecipient contracts. Each subrecipient contract will be assigned to the appropriate individual for monitoring. The monitoring plan with all relevant information will be submitted to Finance and Administration by February 28, 2002. The annual report of monitoring activities will be submitted by October 31 of each year.

Auditor's Comment

As noted in finding 35, TennCare did not adequately monitor its graduate medical school subrecipients.

35. TennCare has still not ensured adequate monitoring of the graduate medical schools

Finding

The previous three audits have reported that TennCare has not ensured adequate monitoring of the graduate medical schools so that requirements related to graduate medical education (GME) payments are met, nor has TennCare advised the graduate medical schools of the audit requirements of subrecipients. The prior year's audit finding addressed four specific issues:

- monitoring was not performed in a timely manner,
- service requirements of students in the stipend program were not monitored,
- the list of students used to calculate the payments to the medical schools was not tested for accuracy, and
- audit reports were not obtained from the state's four graduate medical schools.

The first two issues were resolved in the audit period; however, the last two issues remain.

GME payments are made to the state's four graduate medical schools: (1) the University of Tennessee at Memphis, (2) Vanderbilt University, (3) Meharry Medical College, and (4) East Tennessee State University. The GME payments consist of two components: a primary care allocation component and a resident stipend component. The amount of each school's primary care component is awarded to residents in family practice, internal medicine, pediatrics, or obstetrics during the year of residency, for which the school ensures that the dollars follow the students to their training sites. Under the stipend component, the residents agree to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee. During the year ended June 30, 2001, GME expenditures were approximately $46 million.

The current year's GME contracts were included in the interdepartmental agreement with the Department of Finance and Administration's Division of Resource Development and Support (RDS) to perform the contract monitoring. The activities of RDS do not supplant the primary responsibilities of the agencies the RDS is serving. It is still the primary responsibility of TennCare to ensure compliance with applicable rules. If the division is not effective in its monitoring, TennCare must take other steps to meet these responsibilities.

Testwork revealed that the contract between TennCare and RDS does not require RDS to perform all the procedures needed to ensure adequate monitoring of the medical schools. Some examples of the deficiencies in the contract between TennCare and RDS include the following:

- TennCare has not required RDS to determine if the lists of residents used to determine the primary care component are accurate. The lists of residents are used to calculate the payments to the medical schools. By not verifying the lists of residents, TennCare cannot ensure that it is paying the schools the correct amount. Management

concurred with this portion of the prior-year finding; however, the contract was not revised to include this requirement. According to management, action on other issues was a higher priority than modifying the contract.

- Neither TennCare nor RDS has received audit reports from the non-state graduate medical schools; therefore, they cannot determine if the schools have taken the necessary action to correct audit findings as required by OMB Circular A-133. Management concurred with this portion of the prior-year finding and stated, "We will review the GME and PAR [Department of Finance and Administration, Division of Resource Development and Support, Office of Program Accountability Review] contracts and revise where necessary to ensure compliance with A-133 requirements. In addition, corrective action plans will be requested as appropriate from the GME contractors." However, TennCare did not revise the PAR monitoring contract. Again, according to management, action on other issues was a higher priority than modifying the contract.

OMB Circular A-133 requires TennCare to monitor subrecipients' activities to provide reasonable assurance that the subrecipients administer federal awards in compliance with federal requirements. OMB Circular A-133 also requires TennCare to ensure that required audits are performed and that subrecipients take prompt corrective action on any findings.

The Bureau cannot determine subrecipients' compliance with applicable regulations if appropriate monitoring procedures are not performed and required audits are not obtained. Furthermore, funds could be used for objectives not associated with the grant, and subrecipient errors and irregularities could occur and not be detected.

Recommendation

The Director of TennCare should inform RDS of all the areas that are required to be monitored and amend the interdepartmental agreement to require RDS to perform these monitoring duties. The director should ensure that deficiencies are promptly reported to the graduate medical schools and that the schools promptly submit corrective action plans.

Management's Comment

We concur in part. We have amended the contracts in April 2001 with the schools to include language pertaining to OMB circular A-133 audit requirements. These audits are due 9 months after the end of the fiscal year. Although the interdepartmental agreement with RDS was not amended, a meeting was held in August of 2001 to discuss the audits and modify the scopes of the audits. Among other issues, auditing the accuracy of the list of residents was addressed. We will amend the interagency agreement with RDS to include these items when it is renewed effective July 1, 2002.

Auditor's Comment

It is not clear from management's comment with which part(s) of the finding management does not concur. Management state in their comments that they discussed the audits and scopes of the audits with RDS in August 2001 (after the end of the audit period). Management indicate they specifically addressed the issues concerning auditing the lists of residents and obtaining audit reports from the schools with monitoring staff.

36. The Bureau's overall compliance with the special terms and conditions of the TennCare program needs improvement

Finding

As noted in the prior two audits, the Bureau of TennCare has not complied with all of the TennCare waiver's Special Terms and Conditions (STCs). There are a total of 37 special terms and conditions for the TennCare Waiver; however, only 25 were applicable for the audit period. These special terms and conditions required by the federal Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), describe in detail the nature, character, and extent of anticipated federal involvement in the TennCare waiver. CMS's approval of the waiver and federal matching contributions are contingent upon the Bureau's compliance with the STCs.

The Bureau does not have adequate controls to ensure that requirements of the STCs of the TennCare Waiver are met. In response to the prior findings, management has added this responsibility to an individual (the STC Coordinator) to monitor the status of the STCs. A review of the quarterly STC status report compiled by the STC Coordinator revealed that the status of 15 of the STCs and part of an another STC was unknown in February 2001.

A review of the Bureau's controls and procedures to ensure compliance with the STCs revealed that many areas still need improvement. Testwork revealed instances of noncompliance for 9 of 25 applicable STCs. Problems related to STCs 1, 3, 9, 12, 23, and 24 are repeated from the previous audits. Problems with STCs 19, 20, and 30 were not reported in the previous audit. Previously reported problems with STCs 4, 5, and 35 were resolved during this audit period. The 9 STCs that require improvement are as follows:

- STC 1 – *All contracts and modifications of existing contracts between the state and managed care organizations (MCOs) must be approved by HCFA [CMS] prior to the effective date of the contract or modification of an existing contract. . . . No federal financial participation (FFP) will be available for any contract, modification, or services not approved by HCFA [CMS] in advance of its effective date.* This STC requires the Bureau to submit a contract or a modification of an existing contract 30 days prior to the effective date of the contract. Management stated in response to the prior audit finding that the Bureau is currently in compliance with STC 1. Apparently this statement was made based upon TennCare's submitting the amendments before

the effective date. However, testwork revealed that 5 of 10 amendments (50%) for the period ending June 30, 2001, were not submitted in the required time frame. Although all amendments were approved before the effective dates, the five amendments were submitted from one to 25 days before the effective date rather than 30 days before as required. In a site visit conducted by CMS in October 1999 CMS stated "In order to comply with this STC, Tennessee must submit proposed contract amendments to HCFA [CMS] at least 30 days prior to the effective date of the contract amendment".

- STC 3 – *The state will conduct beneficiary surveys each operational year of the demonstration. The state shall conduct a statistically valid sample of all TennCare enrollees. The survey will measure satisfaction and will include measures of out-of-plan use, average waiting time for physician office visits, and the number and causes of disenrollment. Results of the survey and an electronic file containing the raw data collected must be provided to HCFA [CMS] by the ninth month of each operational year.* It has been noted in the past two audits as well as by CMS in a site visit performed in 1999 that the Bureau did not include all TennCare enrollees in its sample methodology. The survey was conducted with a Computer Assisted Telephone Interviewing System, utilizing a random-digit-dialing-based sample that did not include hard-to-reach beneficiaries who were not included in the sample methodology (e.g., homeless beneficiaries). Management disagreed with the previous audit finding despite having been notified by CMS of its concern over this same issue. The Bureau still has not made and does not plan to make any changes to its operational survey to include hard-to-reach individuals that do not have access to a phone such as disabled individuals and the homeless.

- STC 9 – *The State must develop internal and external audits to monitor the performance of the plans. At a minimum, the state shall monitor the financial performance and quality assurance activities of each plan.* Procedures are performed through the Tennessee Department of Commerce and Insurance for the external audits. STC 9 also requires the development of internal audits to monitor the performance of the health plans. The Bureau is to submit to the CMS Regional Office copies of the internal audits of the plans. Testwork revealed that TennCare has performed internal audits; however, there was no documentation that these audits were submitted to CMS. Management did not respond to this portion of the prior audit finding.

- STC 12 – *HCFA [CMS] will provide FFP at the applicable federal matching rate for . . . Actual expenditures for providing services to a TennCare enrollee residing in an Institution for Mental Diseases (IMD) for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.* Management concurred with this portion of the prior-year audit finding and stated that they "have requested updated information from Mental Health and Mental Retardation." Although this information was received by TennCare, testwork revealed that the Bureau's method of determining expenditures for a TennCare enrollee residing at an IMD is still based

upon estimated expenditures rather than actual. TennCare revised the monthly amount based upon the information from Mental Health, but still charges the same amount each month. Therefore, the Bureau may be under- or overbilling actual expenditures for providing services to a TennCare enrollee residing in an IMD.

- STC 19 – *The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, benefit package, and other operational issues.* All four quarterly reports were submitted after the required deadline to CMS. The reports ranged from 12 to 20 days late.

- STC 20 – *The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of each calendar year of operation.* The report due by April 30, 2001, was not submitted until May 15, 2001.

- STC 23 – *The state must continue to ensure that an adequate MIS is in place and provide evidence of such to HCFA [CMS] upon request. One feature of the system must be to report current enrollment by plan.* The TennCare Management Information System still needs improvement. (See finding 39.) Management concurred with this portion of the prior audit finding and stated that the STC will be "addressed as part of the overall review of the TCMIS." Testwork revealed that management has begun identifying the requirements for the new system and performing strategic planning. However, a new system was not implemented during the audit period. A discussion with a system analyst revealed that the new system is to be implemented in 2003.

- STC 24 – *The State must continue to assure that its eligibility determinations are accurate.* Management stated in the response to prior audit finding that "work is ongoing on STC 24." However, the Bureau's internal control over eligibility determinations is still inadequate. (See finding 12.)

- STC 30 – *The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals.* The Bureau does not have a formal, written plan at the Bureau level to protect the confidentiality of project-related information that identifies individuals.

Recommendation

The Director of TennCare should ensure overall compliance with the Special Terms and Conditions. The Director should continue to communicate with the STC coordinator and other personnel responsible for monitoring the STCs to ensure the Bureau complies with the Special Terms and Conditions.

Management's Comment

We concur with the finding that the Special Terms & Conditions of the waiver should be monitored to assure compliance. We are currently in a period of transition of duties from the Policy Division to Program Communications once staff positions are filled. The STC Coordinator position was vacated in June 2001 and a Policy staff member assumed those duties. In October 2001, this staff member resigned and the position has not been filled due to the freeze on state hiring. The Bureau made the decision to reorganize the two areas and move the STC Coordinator duties under Program Communications. We anticipate that this should occur in early 2002.

STC 1 – We do not concur. TennCare strives to comply with the 30 day advance notification of a contract amendment. However, in some cases, operational necessity may preclude the required timeframe for submittal. In such cases, the Bureau confers with CMS and when the 30 day timeframe is impractical or detrimental to the program, CMS agrees to a shorter timeframe. If not, the requirement is enforced. Given that the 30 day requirement is a federal condition, which is, when necessary in practice, waived by the federal agency concerned, the Bureau is not out of compliance with this STC.

STC 3 – We do not concur. Since the sampling is representative of heads of households in Tennessee, it does not include nursing home residents or homeless persons. It does include disabled persons contacted at home. We offered in 1999 in a response to CMS (then HCFA) to discuss with the contractor the inclusion of these groups if requested by HCFA. However, HCFA did not ask the State to modify the sampling methodology for the beneficiary survey. The sampling methodology is described as follows.

A survey of TennCare recipients was conducted by the UT Center for Business and Economic Research, in conjunction with the UT Social Science Research Institute, between May 15 and June 30, 2000. A survey was also conducted between May 15 and June 30, 2001. The surveys were conducted with a Computer-Assisted Telephone Interviewing system, utilizing a random-digit dialing based sample. A "Household Sample" design was chosen for the survey with the interview being conducted with the Head of Household. Four calls were made to each residence, at staggered times, to minimize nonrespondent bias and to ensure representation for those more mobile respondents who are less likely to be home at the time of any one call. The design chosen was a "Household Sample," with the interview conducted with the Head of Household. The University of Tennessee Social Science Research Institute administered the surveys.

The lowest income residents of Tennessee, which include homeless persons and most nursing home patients, are the least likely to have telephones, so the poorest portion of the population is expected to be somewhat underrepresented in a raw survey. In order to ensure that the responses of all groups were representative of those in the population overall, the large sample size of 5,000 Tennessee households allowed for a weighting of responses of those in this group by their proportion in the population as reported in the 1990 Census.

The 721 TennCare Heads of Households for the survey conducted in the Year 2000 and the 824 Heads of Household for the 2001 survey should thus be considered to be representative of the population of all TennCare heads of households subject to a sampling error of +/-3.5% at the 95% confidence level. That is, we are 95% sure that the parameter estimates in this survey are within 3.5% of what they would be if all TennCare heads of households were interviewed.

It is our conclusion that since CMS is satisfied with the State's plan to comply with STC 3 and has not asked that we change our sampling methodology for the beneficiary satisfaction survey, the sampling methodology is appropriate and is representative of TennCare heads of households.

STC 9 – We concur. We have re-submitted the reports to ensure CMS has received all internal audits and studies. We will retain documentation that reports are submitted in the future.

STC 12 – We concur. We have reviewed this finding and have directed the BHO to develop a quarterly report listing TennCare members having an institutional confinement/episode of more than 30 days, and/or those meeting or exceeding an aggregate annual limit of 60 days. When the report is developed, it will be run for calendar years of 2000 to date. These reports are due by March 1, 2002. When received, the reports will be used to calculate the correct amounts referenced in the audit findings. This procedure will be used to calculate the correct figures each quarter henceforth.

STC 19 – We concur. The four Quarterly Progress Reports for the audit period were submitted after the deadline of 60 days following the end of the quarter. The delay was due to information from two TennCare Divisions not being submitted timely as requested. However, this problem has been corrected; information has been submitted timely, and reports after the audit period have been sent to CMS within the deadline. We will make every effort that future Quarterly Progress Reports will be submitted to CMS within 60 days after the end of the quarter as required in STC 19. There has been no complaint by CMS about the delayed submission of the Quarterly Progress Reports and they recognize that shifting with priorities sometimes necessitates delays.

STC 20 – We concur. The Draft Annual Report for the Year 2000, was submitted after the due date. The report was due April 30, 2000, but was submitted on May 15. The delay was due to Policy staff being involved with two crucial projects that were due in late April and early May 2001, and they were unable to devote the time needed to complete the Draft Annual Report. However, we will make every effort that the Draft Annual Report for 2001 will be submitted to CMS no later than 120 days after the beginning of calendar year 2002, which will be on or before April 30, 2002. There has been no complaint by CMS about the delayed submission of the Quarterly Progress Reports and they recognize that shifting with priorities sometimes necessitates delays.

STC 23 – We do not concur. TennCare Information Systems has taken extensive steps to ensure that the TCMIS meets all federal requirements and believe it is in compliance with STC 23. The current TCMIS was considered state of the art at the time it was activated. However, advances in technology have rendered the current TCMIS in need of updating and further replacement. TennCare is in the process of releasing an RFP which will ultimately lead to the replacement of

the current TCMIS with a state of the art system. System design activities of phase 1 in the development of the RFP to replace the current TCMIS will fully complement functional areas of enrollment and eligibility determination. The new TCMIS will replace the current system and will include features that will provide extensive and enhanced reports on enrollment by plan to CMS. We desire improvement, however; proper redesign, procurement, and implementation of a replacement system takes a significant amount of time. Delivery in 2003 is appropriate.

STC 24 – We concur. The Bureau of TennCare began the Reverification process by mailing out initial reverification notices to approximately 10,000 enrollees. This mail-out was done on December 21, 2001. At the end of January 2002, an additional 25,000 initial reverification notices are scheduled to be mailed out. By March 2002, the Bureau expects to be mailing out approximately 40,000 initial notices per month.

Reverification Timelines

Enrollees receive three reverification notices. The first gives the enrollee 60 days to schedule an appointment. The notice is mailed to the address TennCare has on record and to any alternate address available through the Department of Human Services (food stamp office). If the first notice is returned undeliverable with a new forwarding address, the noticing process and reverification "clock" starts over. If the notice is returned as undeliverable with no forwarding address, TennCare will also contact the enrollee's MCO and attempt to obtain a more current address. If a more current address is obtained, the notice will be re-mailed (the reverification time frame will also re-start).

If the enrollee does not schedule an appointment within 30 days, a second reverification notice is sent with a reminder of making an appointment for reverification. If the enrollee does not schedule an appointment within the original 60 days (within 30 days of second notice), a third notice is sent. This notice informs the enrollee that their coverage will end in 30 days if they do not complete reverification or file an appeal.

STC 30 – We concur. TSOP 038 has been developed as a policy statement, which details plans to protect the confidentiality of information affecting TennCare enrollees. It is the responsibility of the MCOs and the BHOs to ensure that all Medicaid/TennCare enrollees' and potential enrollees' information, materials, and records are protected and treated as confidential information. The MCOs and the BHOs have made this commitment through their contractual arrangements with TennCare. Tennessee Department of Commerce and Insurance (TDCI) is responsible for reviewing and approving provider agreements and subcontract templates. As part of this review, we determine that these agreements contain the requirement that providers, as well as subcontractors with the TennCare HMOs/BHOs, (i.e., claims processing vendors, pharmacy benefits managers, etc.) ensure the confidentiality of enrollee information.

Rebuttal

STC 1 – In a site visit in October 1999, CMS stated,

> . . . Tennessee has not been providing the proposed contract amendments to HCFA [CMS] within an adequate timeframe to allow HCFA [CMS] the full 30 days for review. In order to comply with this STC, Tennessee must submit proposed contract amendments to HCFA [CMS] at least 30 days prior to the effective date of the contract amendment.

During the audit period, this condition still existed with half the amendments not meeting the 30-day requirement. Management has not provided us with written evidence that the requirement has been waived.

STC 3 – Our discussions with CMS personnel during fieldwork revealed that CMS was not satisfied with the sampling methodology. STC 3 requires a sample of all TennCare enrollees. It would seem to be very difficult to adequately weight a telephone survey to represent individuals who do not have telephones.

STC 23 – Management concurred with this portion of the finding in the previous audit and have not developed a new system since their prior comments. The current system was originally designed as a Medicaid Management Information System and has been modified extensively to work for the managed care environment. Management's comments indicate that advances in technology have rendered the current system in need of updating and replacement. Furthermore, management indicate that the new TCMIS will include features to provide extensive and enhanced reports on enrollment by plan to CMS as is required under the STC.

37. Internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations

Finding

As noted in the two previous audits, the TennCare program still did not have adequate internal control for provider eligibility and enrollment to ensure compliance with Medicaid provider regulations. Management concurred with the prior audit finding and corrected two issues concerning the initial verification of out-of-state Medicare crossover providers at the time of enrollment and the reverification of Home Health Care Agency providers by the Division of Mental Retardation Services (DMRS). However, the current audit revealed that TennCare still had the following internal control weaknesses and noncompliance issues that were noted in the previous audit:

- the licensure status of Medicare crossover, managed care organization (MCO), and behavioral health organization (BHO) providers was not reverified after the providers were enrolled;

- TennCare's contract with the Department of Children's Services (Children's Services) did not require this department to comply with Medicaid provider rules and regulations, and as a result, Children's Services did not comply;
- TennCare did not provide DMRS with the Medicaid provider rules and regulations that DMRS should follow, and as a result, DMRS did not comply;
- TennCare did not monitor the enrollment of Medicaid providers at Children's Services and DMRS;
- provider agreements did not comply with all applicable federal requirements;
- departmental rules were not followed;
- documentation that the providers met the prescribed health and safety standards was not maintained for all long-term care facilities; and
- not all providers had a provider agreement, as required.

Responsibility for TennCare provider eligibility and enrollment is divided among the Provider Enrollment Unit in the Division of Provider Services, Bureau of TennCare; the Division of Resource Management in Children's Services; and the East, Middle, and West Tennessee regional offices in DMRS. The Provider Enrollment Unit is responsible for enrolling MCO and BHO providers; Medicare crossover individual and group providers (providers whose claims are partially paid by both Medicare and Medicaid/TennCare); and long-term care facilities, which include skilled nursing facilities and intermediate care facilities.

Children's Services is responsible for the eligibility of the providers it pays to provide Medicaid-covered services to eligible children. DMRS is responsible for the eligibility of the providers it pays to provide services under the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (HCBS-MR waiver) program. (DMRS is responsible for the daily operations of this Medicaid program.) TennCare reimburses Children's Services and DMRS for payments to these providers.

Provider Licensure Not Reverified

Management concurred in the prior year finding and stated that they were working on procedures to implement a license reverification process. However, these procedures were not developed because, according to management in the Provider Enrollment Unit, requested staff positions have not been obtained. The TennCare Provider Enrollment Unit enrolls providers licensed by the Division of Health Related Boards in the Department of Health. Although the Division of Health Related Boards does not notify the Provider Enrollment Unit when a provider's license is suspended or terminated, the Division of Health Related Boards has two systems — one on the Internet and an automated telephone system — so that the current status of a provider's license can be verified. However, during the year ended June 30, 2001, the Provider Enrollment Unit did not use either system to reverify licensure.

The TennCare Provider Enrollment Unit, DMRS, and Children's Services also enroll providers licensed or certified by the Board for Licensing Health Care Facilities (Health Care Facilities) in the Department of Health. Health Care Facilities notified the Provider Enrollment Unit when a provider's certification was suspended or terminated; however, Health Care Facilities did not notify Children's Services or DMRS when a provider's license was suspended or terminated.

Because of the lack of reverification of providers, the Provider Enrollment Unit cannot ensure that only licensed providers are enrolled in the TennCare program as required. The *Rules of the Tennessee Department of Finance and Administration*, Section 1200-13-1-.05, "Providers," states that participation in the TennCare/Medicaid program is limited to providers that "Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice."

Children's Services and DMRS Did Not Always Comply With Medicaid Provider Rules and Regulations

Testwork revealed the following weaknesses regarding provider eligibility and enrollment with DCS and DMRS providers:

- The contract between TennCare and Children's Services does not state, as it should, that Children's Services is required to follow Medicaid federal and state provider rules and regulations.
- The contract between TennCare and DMRS requires TennCare "To provide TDMH/MR (DMR) with complete and current information which relates to pertinent statutes, regulations, policies, procedures and guidelines affecting the operation of this contract." TennCare did not provide DMRS with the Medicaid federal and state provider rules and regulations that DMRS should follow.
- TennCare did not monitor the enrollment of Medicaid providers at Children's Services and DMRS. The Division of Resource Development and Support (RDS) in the Department of Finance and Administration (F&A) performed fiscal monitoring procedures at Children's Services during the year ended June 30, 2001, for the Bureau of TennCare. At that time, F&A verified that providers had a current license. However, TennCare did not require F&A to monitor Children's Services' provider enrollment procedures.

As a result, Children's Services and DMRS did not always comply with Medicaid provider rules and regulations. For example, as discussed in the next two sections of the finding, Children's Services and DMRS did not comply with criteria (3) of the *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 107, "Required Provider Agreement," and criteria 4 and 6 of the *Rules of the Tennessee Department of Finance and Administration*, 1200-13-1-.05, "Providers."

Provider Agreements Not Adequate

The Children's Services and DMRS provider agreements did not comply with federal requirements. Testwork performed on the Children's Services and DMRS provider agreements noted that both did not disclose ownership and control information and information on a provider's owners and other persons convicted of criminal offenses against Medicare or Medicaid.

In addition, TennCare's agreements for individual crossover, MCO, and BHO providers did not require providers to

- keep any records necessary to disclose the extent of services the provider furnishes to recipients;
- furnish to the Medicaid agency, the secretary, or the state Medicaid fraud control unit information required in 42 CFR 431.107; and
- disclose ownership and control information and information on a provider's owners and other persons convicted of criminal offenses against Medicare or Medicaid.

Furthermore, TennCare's agreements with group crossover providers did not require providers to

- keep any records necessary to disclose the extent of services the provider furnishes to recipients; and
- furnish to the Medicaid agency, the secretary, or the state Medicaid fraud control unit information required in 42 CFR 431.107.

Section 4.13(a) of the Tennessee Medicaid State Plan says, "With respect to agreements between the Medicaid agency and each provider furnishing services under the plan, for all providers, the requirements of 42 CFR 431.107 . . . are met." *Code of Federal Regulations*, Title 42, Part 431, Section 107 (b)(1)(2)(3) states,

> A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients; (2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit . . . any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan; (3) Comply with the disclosure requirements specified in part 455, subpart B of this chapter.

Departmental Rules Not Followed

The TennCare Provider Enrollment Unit, Children's Services, and DMRS did not limit participation to providers that complied with the *Rules of the Tennessee Department of Finance and Administration*, Section 1200-13-1-.05 (1)(a), "Providers." The TennCare Provider Enrollment Unit did not require Medicare crossover, MCO, and BHO providers to

- accept, as payment in full, the amounts paid by Medicaid or paid in lieu of Medicaid by a third party;
- not be under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs;
- maintain and provide Medicaid and/or its agency access to all Medicaid recipient medical records for five years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter;
- provide medical assistance at or above recognized standards of practice; and
- comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

In addition, Children's Services and DMRS did not require providers to

- maintain and provide Medicaid and/or its agency access to all Medicaid recipient medical records for five years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter; and
- comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

The *Rules of the Tennessee Department of Finance and Administration*, Section 1200-13-1-.05 (1)(a), "Providers," states:

> Participation in the Medicaid program will be limited to providers who:
> 1. Accept, as payment in full, the amounts paid by Medicaid or paid in lieu of Medicaid by a third party . . . ; 2. Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice; 3. Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs…; 4. Agree to maintain and provide access to Medicaid and/or its agency all Medicaid recipient medical records for five (5) years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter; 5. Provide medical assistance at or above recognized standards of practice; and 6. Comply with all contractual terms and Medicaid policies as outlined in federal and state rules and regulations and Medicaid provider manuals and bulletins.

TennCare Did Not Have Documentation That All Providers Met Prescribed Health and Safety Standards, and Not All Providers Had an Agreement

A sample of payments to intermediate care facilities was tested to determine if TennCare had documentation that the provider met the prescribed health and safety standards and that a provider agreement was on file for the dates of services for which each payment was made. Intermediate care facilities are long-term care providers. For 5 of 60 payments to intermediate care facilities (8%), TennCare did not have the Certification and Transmittal Form for the dates of service tested. However, after testwork was performed, the five forms were obtained from the Board for Licensing Health Care Facilities. Each time the Board for Licensing Health Care Facilities recertifies a long-term care provider, it sends TennCare a Certification and Transmittal Form, and TennCare issues a new provider agreement to the long-term care provider for the certification period. The Office of Management and Budget A-133 Compliance Supplement requires long-term care providers to meet the prescribed health and safety standards. The Certification and Transmittal Form is TennCare's documentation that the provider has met the prescribed health and safety standards.

As mentioned above, the State Plan and 42 CFR 431.107 require that providers have a provider agreement. For 1 of 60 payments tested (2%) TennCare did not have a provider agreement. However, after testwork was performed, the provider agreement was negotiated with the provider to correct the errors. TennCare paid approximately $934 million to intermediate care facilities for the year ended June 30, 2001.

Compliance with applicable rules and regulations, as well as a system of internal control to ensure compliance, is necessary to ensure that the providers participating in the TennCare program are qualified and that they meet all eligibility requirements.

Recommendation

The Director of TennCare should ensure that adequate internal control exists for determining and maintaining provider eligibility. The Director should ensure that procedures are implemented to reverify licensure and to prevent future payments to non-licensed providers.

Children's Services and DMRS should comply with all Medicaid federal and state provider rules and regulations. The Director of TennCare should ensure that these departments are informed of their responsibilities for compliance and that these requirements are added to the contract with Children's Services. The Director should ensure that a knowledgeable staff monitors the enrollment of Medicaid providers at Children's Services and DMRS.

Management and staff should ensure compliance with all Medicaid federal and state provider rules and regulations. The provider agreements should be revised to comply with the State Plan and the *Code of Federal Regulations.* Participation should be limited to providers that meet the requirements of the departmental rules. Management should ensure that documentation is maintained showing that the long-term care providers have met the prescribed health and

safety standards. In addition, all Medicaid/TennCare providers should have a provider agreement and otherwise be properly enrolled before they are allowed to participate in the program.

Management's Comment

We partially concur with this finding.

Provider Licensure Not Reverified

The Provider Enrollment unit has developed procedures for reverifying the licensure renewal for providers participating in the Medicaid Program. The implementation of this new program will ensure providers participating in the program maintain a valid license. However, the implementation of the license reverification program is pending for mainframe system modifications and the hiring of three new staff members.

We are currently working with the IS unit on system modifications to the provider mainframe file. These modifications will allow us to update the license renewal information on the master provider file and generate monthly reports. The monthly reports will assist staff in identifying providers with licenses that are scheduled to expire within the next sixty days. In addition, we are working with our Personnel Department to obtain registers for the three approved positions requested for this new program. We anticipate this program will be operational by May 1, 2002.

DCS compliance with Medicaid provider rules and regulations:

We do not concur that TennCare's contract with DCS did not require DCS to comply with applicable rules and regulations. In the contract between TennCare and DCS signed June 27, 2001, provision A.4.a.vix requires TennCare to provide DCS with Medicaid Federal and State provider rules and regulations, and provision E.10 requires DCS to comply with Medicaid provider rules and regulations.

DMRS compliance with Medicaid provider rules:

We do not concur that DMRS was not provided Medicaid rules and regulations to follow. Over the course of the last year, we have had numerous meetings with DMRS staff and have many times discussed the fact that contracted waiver providers are bound by both the HCBS rules and rules that apply to all waiver providers. In addition, the DMRS Deputy Commissioner was provided copies of last year's audit findings with rule cites and areas of non-compliance identified. The Director of Long-Term Care will draft a cover letter this week and attach the draft findings and copies of the referenced rules for which non-compliance has been identified. This will be sent to the DMRS Interim Deputy Commissioner.

Department Rules Not Followed and Provider Agreements Not Adequate

The Provider Enrollment unit developed and implemented the use of a new Provider Participation Agreement form and revised the current Provider Enrollment application to comply with the requirements of 42 CFR-431.107. We implemented the use of these new forms in

October 2001. Each provider must complete these forms to enroll and participate in the Medicaid Program. Copies of the Provider Participation Agreement and the revised Provider Enrollment applications were given to the Auditor in October 2001.

TennCare Did Not Have Documentation That All Providers Met Prescribed Health and Safety Standards and Not all Providers Had an Agreement:

We do not concur. The Provider Enrollment unit receives the Medicare/Medicaid Certification and Transmittal forms from Health Care Facilities (HCF). These forms certify that the Long Term Care Facility has met the required regulations to operate a nursing home in Tennessee. The C&T forms received from HCF are the documentation that the LTCF has met all of the requirements including the prescribed health and safety standards.

Not All Providers Had Agreements:

To ensure all intermediate care and skilled nursing facilities' provider files contain the appropriate forms and agreements, the reviewer must complete an enrollment checklist. We currently depend on HCF to notify our office of nursing home facilities needing new contracts. However, we are currently working with the IS unit on system modification to track all LTCF recertification due dates and to generate monthly reports to alert staff of upcoming contract termination dates.

Provider enrollment monitoring of BHO providers:

TDMHDD, through an MOU (Memorandum of Understanding) with TennCare, has the responsibility for monitoring the enrollment of providers. They have agreed to include the verification of eligibility as a part of their network and provider review.

Provider enrollment monitoring of MR providers:

With respect to monitoring of provider enrollment, the TennCare Division of Long-Term Care (TDLTC) is reviewing DMRS provider enrollment processes and has asked for the processes to be reviewed by the Division of Provider Services. Recommendations for changes in the process will be submitted to DMRS upon completion of the review. Preliminary discussions of recommendations have been informally discussed during meetings with DMRS staff. In addition, since July 2001, summaries on new providers and providers expanding to different regions have been submitted to TDLTC for review and approval.

Regarding the Certification and Transmittal Forms for ICFsMR, these forms are submitted to the Provider Services Unit. The TDLTC Director will meet with the Director of the Provider Services Division to determine a mechanism of ensuring provider eligibility and to make appropriate revisions to the provider agreement.

Adequate provider agreements:

Regarding the DMRS/TennCare Interagency Agreement and provider agreements with MR Waiver Providers, staff from the Office of Health Services have been working to revise contract language. Revisions were made to the Interagency Agreement; however, revisions to the

Provider Agreement have not yet been completed. The revisions are to be completed so that Providers will sign the revised provider agreement for the upcoming contract period which begins July 1, 2002.

DMRS notification of suspension/termination of provider certification:

The majority of MR waiver providers are not required to be certified and are not licensed/certified by Health Care Facilities. This would apply to Home Health Agencies providing waiver services. Development of procedures to correct this finding for those providers which do require certification will be completed in conjunction with DMRS.

Monitoring of provider enrollment:

TDLTC is reviewing DMRS provider enrollment processes and has asked for the processes to be reviewed by the Division of Provider Services. Recommendations for changes in the process will be submitted to DMRS upon completion of the review. Preliminary discussions of recommendations have been informally discussed during meetings with DMRS staff. In addition, since July 2001, summaries on new providers and providers expanding into different regions have been submitted to TennCare for review and approval.

Certification and Transmittal Forms for ICFsMR:

These forms are submitted to the Provider Services Unit. The TDLTC Director will meet with the Director of the Provider Services Division to determine a mechanism of ensuring provider eligibility and to make appropriate revisions to the provider agreement.

Rebuttal

DCS compliance with Medicaid provider rules and regulations:

Management's comments pertain to the contract that was to be effective July 1, 2001, for the period ending June 30, 2002. The contract that was in place during the audit period was the same contract that was in place in the previous audit. Management fully concurred with this audit finding last year.

DMRS compliance with Medicaid provider rules:

During fieldwork when we discussed our concern of provider agreements not containing all the terms required by Medicaid rules with DMRS' central office staff, it appeared that they were not aware of the rules. In addition, during fieldwork we provided these rules to DMRS' central office staff. If management were aware of all provider rules and regulations, it is unclear why for the third consecutive audit, the provider agreements did not contain all the guidelines required by these same provider rules and regulations.

TennCare Did Not Have Documentation That All Providers Met Prescribed Health and Safety Standards

We agree that the Certification and Transmittal forms serve as documentation of compliance with provider health and safety standards. Although management did not concur with this portion of the finding, they did not address the lack of forms noted in the finding. As stated in the finding, TennCare did not have 5 of 60 forms. These forms were not in the provider's file at the time of audit. Only after we brought the matter to staff's attention were these forms obtained.

38. TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud

Finding

As noted in the previous two audits, the Bureau of TennCare still has not complied with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud for areas of the program that are still under the fee-for-service arrangement. Management concurred with the finding and stated,

> The TennCare Bureau will develop and implement within the next twelve months a comprehensive plan to address surveillance and utilization control and identification of suspected fraud in those areas of the program that still operate on a fee-for-service basis.

Discussions with management in July 2001 revealed that work has begun on developing a comprehensive plan. However, during the audit period, a comprehensive plan was not completely developed or implemented.

In 1994, the state received a waiver from the Health Care Financing Administration to implement a managed care demonstration project. However, the services provided in the long-term care facilities, services provided to children in the state's custody, services provided under the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled, services provided for enrollees who are both TennCare and Medicare recipients (Medicare cross-over claims), and pharmacy claims for individuals that are recipients of TennCare and Medicare are paid on a fee-for-service basis. Discussions with key TennCare management revealed that

- TennCare has no "methods or procedures to safeguard against unnecessary utilization of care and services," except for long-term care institutions;
- for all types of services, including long-term care, there are no procedures for the "ongoing post-payment review . . . of the need for and the quality and timeliness of Medicaid services"; and

- there are no methods or procedures to identify suspected fraud related to "children's therapeutic intervention" claims and claims for the Home and Community Based Services waiver for the mentally retarded.

These same conditions existed during the two preceding audits.

According to the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations,* Title 42, parts 455, 456, and 1002,

> The State Plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. In addition, the State must have: (1) methods or criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and, (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials. . . .
>
> The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

In addition, in 1992 the State Medicaid Agency told the federal grantor in the Tennessee Medicaid State Plan that

> A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services.

However, audit testwork revealed that during the audit period, there was no statewide program of surveillance and utilization control. This condition has existed during the previous two audit periods.

Although much of the TennCare program operates differently than the former Medicaid fee-for-service program, for areas that still operate under the Medicaid fee-for-service program, effort is needed in the form of program-wide surveillance and utilization control and identification of suspected fraud, to help ensure that state and federal funds are used only for valid medical assistance payments.

Recommendation

The Director of TennCare should ensure development of the comprehensive plan for utilization control and identification of fraud for all areas of the program that are fee-for-service based. When the plan is completed, the Director should ensure that it is implemented.

Management's Comment

We concur. The processes involved have been reviewed and policies and procedures developed to address the issues involved. Significant steps have been taken toward implementing a Post-payment review process for LTC waiver programs. The TennCare Division of Long-Term care (TDLTC) is currently in the process of establishing an LTC Quality Monitoring Unit. Staff positions have been approved and some have been filled. Two nurse auditors from the Comptroller's office have been reassigned to TDLTC and are being trained to review records for HCBS Waiver programs. Draft tools have been developed and are being revised and tested. These nurses began formal record reviews in November 2001. A process for post-payment reviews for the MR Waiver program is being developed first, due to the need to develop such process for compliance with the MR Waiver Corrective Plan. The process developed will then be modified and implemented for other LTC waiver programs.

With respect to fraud and abuse, a new process will require the respective programs and the TennCare Quality Oversight and Program Fraud organizations to work together to assure the finding is addressed. The Bureau will develop a plan to address this issue in collaboration with Program Fraud organizations.

39. The TennCare Management Information System lacks the necessary flexibility and internal control

Finding

As noted in three previous audits, management of the Bureau of TennCare has not adequately addressed critical information system internal control issues. In addition, the TennCare Management Information System (TCMIS) lacks flexibility it needs to ensure that the State of Tennessee can continue to run the state's $5.3 billion federal/state health care reform program effectively and efficiently. Management concurred with the prior finding and indicated it had begun the process of identifying the requirements for the new system and performing strategic planning. Management's objective is to analyze current TennCare operations and make recommendations of the most effective way to update or renovate the current TCMIS system. According to Information Systems (IS) staff, the implementation of a new TCMIS is to occur in 2003.

Because of the system's complexity, frequent modifications of the system, and because this system was developed in the 1970s for processing Medicaid claims, TennCare staff and Electronic Data Services (EDS) (the contractor hired to operate and maintain the TCMIS) primarily focus on the critical demands of processing payments to the managed care organization, behavioral health organizations, and the state's nursing homes rather than developing and enhancing internal control of the system. This has contributed to a number of other findings in this report.

Recommendation

The Director of TennCare should address internal control issues and pursue the acquisition of a system designed for the managed care environment. Until a new system is acquired, the Bureau should continue to strengthen the system's internal control to prevent or recover erroneous payments. TennCare should ensure that an updated system is implemented timely that more effectively supports TennCare's operations.

Management's Comment

We partially concur with this audit finding. We agree that the current system is outdated. We have begun preparations for implementing a new TennCare Management Information System by Oct 1, 2003. The new TCMIS will be a Medicaid HIPAA (Health Information Portability and Accountability Act) Compliant Concept Model.

A contractor has been chosen to assist with the new TCMIS strategic analysis and procurement process.

TCMIS requirements analysis has been completed. A TCMIS Advanced Planning Document (APD) has been approved by the Center for Medicare and Medicaid Systems (CMS). The APD also includes a Data Warehouse/Decision Support System (DSS) which will also be implemented in conjunction with the replacement TCMIS.

The draft Request for Proposal (RFP) associated with the new TCMIS has been developed and is under review by CMS staff. The current work schedule calls for the RFP to be released on February 28, 2002. TennCare Information Systems management and Fox Systems are working aggressively to meet that deadline. This is a top project for the Bureau of TennCare, and completion of this project will address many of the issues identified throughout this audit.

We partially concur that the current system lacks sufficient controls. Some of the issues stated in the finding are related to policy directed by management and not a limitation of TCMIS. However, the current system has numerous internal controls which are continuously verified. For example:

- The TennCare Information staff receives periodic updates of recipient information from the TennCare Information Line, recipients, system generated reports, providers and MCO's on an ongoing basis. The information is manually validated by comparing the information on the system to information that is on the update and ensuring that the recipient is in the system, that the name is correct, that the social security number is correct for that person, and that the format and value of other identification numbers is correct before it is added to or modified in the TennCare system.
- Information received on newborns from both the TennCare Information Line and from the individual MCO's is verified from system generated reports before entry into

the system. The information from the reports is compared to the original inputs to ensure that the data was entered and processed correctly. These verifications include infant date of birth, that a mother is assigned, and the mother's TennCare status.

- TennCare is responsible for changing addresses for the uninsured/uninsurable, inactive Department of Human Services (DHS), and inactive Supplemental Security Income (SSI) recipients. Inactive DHS and inactive SSI are enrollees who currently have TennCare coverage but are closed on the DHS and SSI systems. Recipient address changes come from many sources in both paper and electronic (tape) formats. TennCare staff compares information that is in the system to that on the reports and makes or requests changes as necessary.
- Notification regarding enrollees who are no longer residents of Tennessee may be received by the various units within the Bureau of TennCare, TennCare affiliated agencies (e.g., DHS), a county health office (CHO), the CHO HelpDesk, the Program Integrity Unit, etc. Information System staff reviews the written request or report to determine the member(s) to be terminated and identify the member's Social Security Number. The staff member researches eligibility, reviews the recipient eligibility history to determine whether or not the request includes an enrollee who is DHS/SSI eligible, and terminates the recipient if they do not meet eligibility criteria.

The TennCare Information Systems staff reviews the results of all operations at regular intervals. Furthermore, TennCare has documented policies and procedures in place to handle and correct any errors which are found in the information that is processed.

We concur that we focus heavily on ensuring that proper payments are made to the various providers throughout Tennessee. However, TennCare Information Systems also takes the accuracy of the system very seriously and keeps a careful watch on the internal controls present in the system. TennCare Information Systems management continuously monitors and modifies internal controls as necessary to ensure that all TennCare data is processed accurately.

Rebuttal

Numerous findings in this report indicate that the system does not have adequate internal control. For example, these findings indicate that the TennCare Bureau

- has weak system security internal control (finding 40);
- does not pay claims in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (finding 21); and
- produces inconsistent premium reports (finding 33).

While some of the findings in this report relate to policy issues directed by management, the lack of policies or inadequate policies to require staff to implement needed controls as

indicated in this audit report still result in inadequate internal control. As illustrated in this audit report, ineffective system controls result in noncompliance and questioned costs.

40. Controls over access to the TennCare Management Information System need improvement

Finding

As noted in the three previous audits, one of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The Director of TennCare is responsible for ensuring, but did not ensure that, adequate TennCare Management Information System (TCMIS) access controls were in place during the audit period. As a result, deficiencies in controls were noted during system security testwork.

The TCMIS contains extensive recipient, provider, and payment data files; processes a high volume of transactions; and generates numerous types of reports. Who has access, and the type of access permitted, is critical to the integrity and performance of the TennCare program. Good security controls provide access to data and transaction screens on a "need-to-know, need-to-do" basis. When system access is not properly controlled, there is a greater risk that individuals may make unauthorized changes to the TCMIS or inappropriately obtain confidential information, such as recipient social security and Medicaid identification numbers, income, and medical information. Audit testwork revealed the following discrepancies.

Justification Forms Not Obtained for Existing Users

Management concurred with this portion of the prior audit finding and stated, "TennCare Information Systems will continue coordinating efforts to ensure that proper access forms are obtained for all TennCare and other users who require interaction with the TennCare system." However, testwork revealed that justification forms have not been obtained for all existing users outside of the Bureau of TennCare. Access to TCMIS is controlled by Resource Access Control Facility (RACF) software, which prohibits unauthorized access to confidential information and system transactions. The TennCare security administrator in the Division of Information systems is responsible for implementing RACF, as well as other, system security procedures.

The security administrator assigns a "username" ("RACF User ID") and establishes at least one "user group" for all TennCare Bureau and TCMIS contractor users. RACF controls access by allowing each member of a user group to access a set of transaction screens.

On July 12, 1999, TennCare started requiring all users who are new to TennCare's system to fill out standardized justification forms requesting users to justify their reasons for access to TennCare's system. When asked why existing users were not asked to complete the forms, the security administrator responded that she had not been told to obtain these forms for existing users. In response to the prior audit finding, the TennCare security administrator obtained forms for existing users inside the TennCare bureau. However, forms had not been obtained for all existing users outside the TennCare Bureau. The security administrator stated that she was not

instructed to obtain these forms for these users. Testwork revealed that 12 of 45 users outside the Bureau tested (27%) did not have "Justification for TennCare Access" forms properly filled out and completed. Not requiring existing users outside the Bureau of TennCare to sign justification forms makes it more difficult to monitor and control user access. For example, it is not possible to compare the type and level of access needed and requested with the type and level of access given.

Unnecessary Access to TCMIS

Management concurred with this portion of the prior audit finding and stated that system maintenance requests have been initiated to the TennCare facilities manager concerning the access issues. However, as of November 13, 2001, the problem had not been resolved. User access testwork revealed, as it did in the prior audit, that all users in the default group (a group automatically assigned to all Department of Health and TennCare RACF users) had the ability to update one screen. This could be accomplished by typing over the "function" field and replacing INQ (inquiry) with CHG (change). Then users could make changes to the screen and press a particular function key to update. Management sent a work request to the contractor, EDS, on August 11, 1999, to explore the problem but have not made correcting this issue a priority.

Security Administration Not Centralized

Management concurred with this portion of the prior audit finding and stated, "Centralization of TCMIS under TennCare Information Systems' security administrator was implemented as of November 3, 2000." However, testwork revealed that the security administrator for the Department of Health, who is separate from TennCare's security administrator, has the ability to give users access to TCMIS through the Department of Health's default group. The Department of Health default group has access to 87 TCMIS screens and has approximately 3,000 users. During the audit period, in an attempt to correct the problem, management removed the TCMIS transactions from the Department of Health's default group. However, the removal of the transactions interrupted the ability of users in the Department of Health to perform their TennCare responsibilities. As a result, the transaction screens were added to the default group once again. According to the security administrator, management has not made another attempt to correct the problem. Consequently, the Department of Health's security administrator still has the ability to add users to TCMIS through the Department of Health's default group.

In addition, testwork revealed that the security administrator for the Department of Human Services (DHS) has the ability to add users to TennCare user groups without notifying TennCare's security administrator. Furthermore, justification forms were not obtained by the DHS security administrator for users added to these groups. In addition, TennCare did not monitor the activities of the DHS security administrator as they relate to TennCare. When access to TCMIS is decentralized, it is more difficult to monitor and control.

Recommendation

The Director of TennCare and the TennCare security administrator should ensure that the standardized authorization forms are obtained for all current and future users that have access to TCMIS. Access levels for all screens should be reviewed to guarantee that only authorized users have the ability to make changes. Responsibility for TCMIS security should be centralized under the TennCare security administrator. Using the justification forms, the Director should determine which users employed by the Department of Health in the Department of Health default group need access to TCMIS and add the identified users to a TennCare user group that has access appropriate to the needs of the user. After access has been given to the identified Department of Health users, TCMIS transactions in the Department of Health default group should be removed. In addition, the ability of the DHS security administrator to add users to TennCare user groups should be removed, or at a minimum, TennCare should insist that DHS collects justification forms for all users. If the Director of TennCare elects to continue to permit the DHS security administrator to add users to TennCare user groups, formal monitoring procedures should be implemented. These monitoring procedures should be written and all monitoring activities should be documented.

Management's Comment

We partially concur with this audit finding. TennCare Information Systems has taken action on each of the previous audit findings. We have attempted to insure that adequate security measures are in place for all access to the TCMIS. However, due to the complexity of the existing TCMIS, some of the security processes put in place prevented users needing access to the system from performing functions that were needed. We have continued to review our security procedures to ensure that adequate security measures are in place to the TCMIS as well as adequate user accessibility.

TennCare Information Systems management reviewed security forms based on a previous audit finding and modified the form to include justification. As new users were granted access to the TCMIS, the new justification form was submitted. In addition, in cases where justification forms for existing users could not be located, justification was requested from section managers and the security forms were updated. We concur that there are external agencies who have access to the TCMIS. We have aggressively attempted to obtain signed justification for users in those agencies. We have obtained justification from all users in the Department of Health (DOH) and are currently obtaining justifications from users in the Department of Human Services (DHS).

We concur that previous audit findings identified that there were users who potentially had unnecessary access to the TCMIS. It was identified that the default group for the Department of Health (DOH) granted those users access to some transactions which may not be needed. In an effort to prevent this, TennCare Information Systems removed DOH access to this group in the latter half of 2001. However, by doing this, these users were prevented from performing other job related functions. We reinstated the default group and began the process of identifying

how we could accomplish adequate security access as well as adequate user access. We have established a group, which will be used to grant external users access to only those transactions, needed to perform their job responsibilities. This group will be implemented on February 6, 2002. In addition, it has been identified that there are TCMIS transactions that allow update capability by replacing INQ with CHG. As stated in the audit finding, TennCare Information Systems sent a work request to the contractor, EDS, to correct this situation. A portion of this work request was completed in October 1999. This work request was amended with the additional transactions that were identified by the previous audit. This amendment has been addressed with the contractor as a top priority and will be discussed in weekly status meetings until completed.

TennCare Information Systems management does not concur that the systems administrator at Department of Health (DOH) has the ability to grant access to the TCMIS. All access to the TCMIS is performed by TennCare's security administrator. A request is submitted from DOH security administrator to the TennCare security administrator with justification for TCMIS access. We do concur that if a request is made from the DOH security administrator to add a user to the default group, this may allow for access to unnecessary transactions. However, the new group created for external agencies/users will be in place on Wednesday, February 6, 2002, which will correct unnecessary access to the TCMIS.

The current TCMIS has many controls and edits included which allow for extensive internal access control and audit capabilities. However, TennCare Information Systems management will concede that external access control from other state agencies such as Department of Health (DOH) and Department of Human Services (DHS) could be improved. Therefore, Information Systems is currently in negotiations with DOH and DHS to develop a no-cost inter-departmental contract that will include enhanced procedures to control access to the TCMIS. The execution of these contracts will provide administrative procedures and controls over access to the MIS as well as provide for audits by the comptroller.

Rebuttal

Although management do not concur that the Department of Health security administrator has the ability to grant access to the TCMIS, they do acknowledge that "if a request is made from the DOH security administrator to add a user to the default group, this may allow for access to unnecessary transactions." Having access to transactions in the default group results in unnecessary access to TCMIS. Furthermore, if there is not necessary access being given, it is unclear why management say they will create a new group on "February 6, 2002 which will correct unnecessary access to the TCMIS."

41. TennCare has not established a coordinated program for ADP risk analysis and system security review

Finding

As noted in the preceding four audits, TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and system security review of the TennCare Management Information System (TCMIS). In response to the prior finding, the Director stated that "HCFA [Health Care Financing Administration] has documented that the BCCP [TennCare Business Contingency Continuity Plan] fulfills all federal requirements associated with infrastructure risk mitigation." On several occasions, we requested documentation to support this claim. In a meeting with the Director of Information Systems, the Director stated that he would get the information. However, no such documentation was provided. The Bureau has relied on the Department of Finance and Administration's Office of Information Resources (OIR) for security of TCMIS. According to OIR's policy number one, Agency Management is to "provide for an agency administrative review of security standards, procedures and guidelines in light of technical, environmental, procedural, or statutory changes which may occur." However, the Bureau has not complied with federal regulations, which require establishing a program for ADP risk analysis and system security review.

According to Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations*, Title 45, Subtitle A, Part 95, Section 621, such an analysis and a review must be performed on all projects under development and on all state operating systems involved in the administration of the Department of Health and Human Services' programs. TCMIS is such an operating system and is one of the largest in the state.

The risk analysis is to ensure that appropriate, cost-effective safeguards are incorporated into the new or existing system and is to be performed "whenever significant changes occur." The system security review is to be performed biennially and include, at a minimum, "an evaluation of physical and data security operating procedures, and personnel practices." Furthermore, "The State agency shall maintain reports of their biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site review."

If TennCare is to rely on TCMIS for the proper payment of benefits, a security plan, which includes risk analysis and system security review, must be performed for this extensive and complex computer system. OMB A-133 requires the plan to include policies and procedures to address the following:

- Physical security
- Equipment security to protect equipment from theft and unauthorized use
- Software and data security
- Telecommunications security
- Personnel security

- Contingency plans to meet critical processing needs in the event of short- or long-term interruption of service
- Emergency preparedness
- Designation of an agency ADP security manager

We reviewed TennCare's BCCP, other TennCare policies and procedures, and OIR polices for compliance with the above requirements. These policies do not address all the requirements of the federal regulation. These policies do not address physical security, equipment security, telecommunications security, and personnel security. In addition, testwork also revealed that TennCare did not conduct the required system security reviews on a biennial basis.

Recommendation

The Director of TennCare should ensure that the Director of Information Services promptly develops and implements procedures for ADP risk analysis and system security review. The Director of TennCare should look to staff to take the initiative in analyzing and reviewing these important areas with or without guidance from HCFA. Otherwise, the Director of TennCare should obtain, and provide to us, documentation of concurrence by HCFA of TennCare's actions as a valid ADP risk analysis and system security review. Once procedures are in place, the Director of TennCare should monitor the procedures implemented and ensure that the appropriate actions have been taken.

Management's Comment

We partially concur with this finding. TennCare representatives met with auditors and were presented with issues that the auditors felt were not sufficiently covered through the TennCare Business Continuity and Contingency Plan (BCCP). TennCare representatives informed the auditors that since TennCare computer resources fell under OIR jurisdiction that published OIR security documentation applied to TennCare. The auditors requested that TennCare provide such documentation for review. TennCare representatives obtained and provided the auditors with what they believed to be such information. The auditors then informed the TennCare representatives that the provided information did not meet the requirements. The TennCare representatives then referred the auditors to OIR for further explanation of the OIR procedures.

The auditors also requested a copy of the TennCare Security Procedures manual. TennCare representatives informed the auditors that the procedures were contained in a variety of documents. The auditors requested that TennCare create a single document which covers all aspects of TennCare security. TennCare representatives agreed to create the document which is currently under development.

TennCare management has made a written request to CMS for written verification that the current TennCare Business Continuity and Contingency Plan (BCCP) meets all federal requirements and guidelines for security.

TennCare management is currently in the process of developing an ADP risk analysis document and matrix. This document and matrix will become a component of the existing TennCare Business Continuity and Contingency Plan (BCCP). This risk analysis will include coordinated input from both the Department of Health (DOH) and the Department of Human Services (DHS). This requirement will become a component of the contract discussed in the TennCare response to finding 40 of this report.

Rebuttal

It is not clear from management's comment with which part(s) of the finding management does not concur. Management's comments do not dispute any of the facts in the finding. During fieldwork we examined all the policies mentioned in the finding that were provided by management. As noted in the finding, these policies did not cover all the areas required by the regulation. In addition, compliance with this requirement is also dependent upon preparation of a biennial summary report. Management has never prepared such a report.

SUBRECIPIENT MONITORING

Our objectives were to determine whether

- the Division of Resource Development and Support (RDS) was properly monitoring subrecipients in accordance with the Single Audit Act and performing its duties as the lead agency for the statewide monitoring system required by Finance and Administration Policy 22, "Subrecipient Monitoring"; and
- RDS was properly billing departments and divisions which used RDS to monitor subrecipients.

We interviewed key personnel and reviewed the procedures that were being used by RDS. To determine if subrecipients were adequately monitored in accordance with the Single Audit Act and Policy 22, we tested a nonstatistical sample of subrecipients to determine if RDS monitors' work covered all core areas and if the monitoring reports were issued timely. In addition, we tested a nonstatistical sample of billings to determine if the billings had adequate support, appeared proper, and were mathematically accurate.

Testwork revealed that RDS was adequately monitoring subrecipients and was properly performing its duties as required by Policy 22. Also, RDS billings were appropriate and adequately supported. However, we determined that RDS was not performing some of its duties in a timely manner, as discussed in finding 42 and that its services were not billed timely, as discussed in finding 43.

42. Activities of the Office of Program Accountability Review were not performed in a timely manner

Finding

The Office of Program Accountability Review (PAR) is a part of the Division of Resource Development and Support. During the year ended June 30, 2001, PAR was responsible for monitoring subrecipients of 12 state agencies and 4 divisions of the Department of Finance and Administration. Eventually, PAR will be the centralized office responsible for the subrecipient monitoring needs of all state agencies. As part of their duties as the centralized monitoring office, they are to enter interdepartmental contracts or memoranda of understanding to outline their monitoring responsibilities and billing procedures, issue reports to the affected agencies, and report on their monitoring activities to the Commissioner of the Department of Finance and Administration and the Comptroller of the Treasury. These duties have not been performed in a timely manner.

Interdepartmental contracts and memoranda of understanding were not obtained timely

Approval signatures on the interdepartmental contracts and memoranda of understanding were dated after monitoring work had already begun. Eight contracts were determined to have become effective during the year ended June 30, 2001. For three of the contracts (38%), PAR monitors had entered the field before the contracts had been signed and approved. Contracts should be properly signed and dated by all parties before monitoring begins to ensure they are properly executed documents.

Reports were not issued in a timely manner

PAR did not issue its subrecipient monitoring reports in a timely manner. Based on discussion with PAR personnel and review of current policy, reports are to be issued within 30 days of the field exit date. Nine of 23 reports reviewed (39%) were not issued within this 30-day time period. The reports were issued from 33 to 156 days after the field exit date. Without timely issuance of reports, agencies and divisions may not know for months what kind of problems were discovered when their subrecipients were monitored. Likewise, corrective action by subrecipients is delayed. The absence of a report tracking system may have contributed to this situation.

PAR did not submit an annual report

PAR did not submit an annual report to the Comptroller of the Treasury by November 30, 2000. *The Tennessee Subrecipient Monitoring Manual*, Attachment A, part 18, states that "the Division of Resource Development and Support shall submit an annual report of monitoring activities of all subrecipients to the Commissioner of Finance and Administration and the Comptroller of the Treasury by November 30 of each year." As of October 29, 2001, the report had still not been received.

Conclusion

PAR was given the responsibility of monitoring subrecipients in order to establish a coordinated and centralized monitoring system. Fully executed contracts and annual reports are essential for the coordination and accountability of such a system. Expeditious reporting to the agencies is necessary for corrective action to occur in a timely manner.

Recommendation

The Director of PAR should ensure that contracts are initiated far enough in advance to allow all necessary parties to approve the contract before the review commences. The director should ensure the reports are issued timely. A report tracking system should be considered to help achieve this goal. In addition, the director should submit an annual report of monitoring activity to the Comptroller of the Treasury by November 30 of each year.

Management's Comment

Interdepartmental contracts and memoranda of understanding were not obtained timely

We concur. Greater care will be exercised to help ensure interdepartmental contracts and memoranda of understanding are fully executed prior to rendering services.

Reports were not issued in a timely manner

We concur in part. Approximately 80% of the nearly 1900 contracts reviewed in fiscal year 2001 had reports issued within 30 business days after the completion of fieldwork. In addition, often times there are extenuating circumstances that create unavoidable reporting delays.

Greater care will be exercised to help ensure reports are issued timely. During fiscal year 2002, a report tracking system has been implemented to assist in this effort.

PAR did not submit an annual report

We concur. Due to staff turnover at the Division and PAR Director positions during fiscal year 2001, the annual reporting function was not performed summarizing the monitoring activities for fiscal year 2000. The annual report for fiscal year 2001 was submitted on November 30, 2001, and will be submitted annually going forward.

43. The Department of Finance and Administration is not following billing policies

Finding

The Department of Finance and Administration, Office of Business and Finance (OBF) initiates billings for monitoring services performed by the Office of Program Accountability Review (PAR). During the year ended June 30, 2001, these billings did not occur within the appropriate time limitations. OBF uses type J journal vouchers to bill 12 agencies and 2 divisions that have monitoring agreements with PAR and type H journal vouchers for the other 2 divisions that utilize PAR. The Department of Finance and Administration's Policy 18, *Journal Vouchers - Type J,* states, "Billing departments should initiate journal voucher billings as quickly as possible after expenses/expenditures occur, according to the following guidelines: . . . Billings totaling $2,500.01 through $350,000.00 shall be billed at least monthly. Billings totaling more than $350,000.00 shall be journal vouchered within 5 working days after the expense/expenditure is incurred or the service is rendered."

For the year ended June 30, 2001, one bill was sent to each agency and division for monitoring services performed from July 2000 to December 2000. All billings for this time period were greater than $2,500, and the highest bill was for $537,561. OBF later cancelled two of these billings and rebilled the agencies for monitoring services performed from July 2000 to April 2001. In addition, two of the agencies were billed $147,491 and $307,717 for January 2001 to April 2001. Apparently, the office was experiencing problems with the system used for cost allocation, and this resulted in the late billings.

Policy 18 was implemented to facilitate the state's compliance with the Cash Management Improvement Act of 1990. Journal vouchers that reallocate expenditures among agencies often have an effect on the receipt of federal funds. Late billings related to PAR monitoring could cause avoidable problems with cash management for the state. In addition, the amounts from the accounting system that the agencies use for their monthly budget analyses are incomplete when billings are not performed timely. The inaccurate amounts could cause agencies to overspend their budget.

Recommendation

The Director of Administrative Services should monitor the billing process used by the Office of Business and Finance for PAR billings and ensure that Policy 18 is followed. Changes should be made as necessary to the cost allocation process to facilitate timely billings.

Management's Comment

We concur that billings should be completed timely. FY 2001 was the beginning of a major expansion of monitoring conducted by Finance and Administration. Numerous positions were transferred to F&A and many start up and training issues were addressed in the fall of 2000.

All costs associated with monitoring (including start up costs) were billed to all participating agencies. Billings could not be completed until a general overhead rate for the entire fiscal year was estimated. Due to the complexity of the transition, all operational plans and the estimated annual overhead rate could not be finalized until December 2000. Billings have been completed timely since that time.

BUDGETING

Our objectives were to determine whether

- the 2000-2001 approved appropriation bill reconciles to the original budget recorded on the State of Tennessee Accounting and Reporting System (STARS);
- the original budget reconciled to the final budget per STARS and if there was adequate support and authority for any revisions made to the original budget;
- the budget document contained the information required in Section 9-4-5106, *Tennessee Code Annotated;*
- the percentage increase in the recommended appropriations from state tax revenues does not exceed the percentage increase of estimated Tennessee personal income for the succeeding fiscal year unless the legislature passes a bill allowing a larger increase;
- the State Funding Board has reviewed the report on estimated growth of the state's economy for June 30, 2001, and commented on its reasonableness; and
- the State Funding Board provided a list of approved state tax revenue sources to the Department of Finance and Administration, and whether the department estimated revenues from the sources provided by the Board as required by Section 9-4-5104, *Tennessee Code Annotated*.

We interviewed key personnel to obtain an understanding of the budgeting process from the initial proposals submitted by departments and agencies to the final budget recorded on STARS. We then obtained the appropriation bill for 2000-2001 and reconciled, for a nonstatistical sample of agencies, the approved appropriation bill amounts to the original budget recorded on STARS. We also reconciled the original budget to the final budget per STARS and reviewed the support and authority for any revisions made by the department to the original budget. We reviewed the budget document to determine whether it contained the required information. By reviewing the State Funding Board minutes, we determined if the State Funding Board has reviewed and commented on the reasonableness of the report on the estimated rate of growth of the state's economy for the year ended June 30, 2001. Also, by reviewing Board minutes, we determined if the State Funding Board provided a list of approved state tax revenue sources to the Department of Finance and Administration and whether Finance and Administration estimated revenue from the tax sources provided by the Board. Using this information, we determined if the percentage increase of recommended appropriations from state

tax revenues did not exceed the percentage increase of estimated Tennessee personal income for the succeeding fiscal year.

Based on the testwork performed, we determined that the budget document and appropriation bill reconciled to amounts recorded in STARS, contained the information required in *Tennessee Code Annotated*, and that revisions were adequately supported and authorized. The percentage increase in the recommended appropriations from state tax revenues did not exceed the percentage increase of estimated Tennessee personal income for the succeeding fiscal year. The State Funding Board reviewed the report on estimated growth of the state's economy, commented on its reasonableness, and provided a list of approved state tax revenue sources to the department. The department estimated revenues for these sources as required by *Tennessee Code Annotated*.

REAL PROPERTY AND CAPITAL PROJECTS MANAGEMENT

Our objectives were to determine whether

- building commission contracts are only awarded as is required by Section 4-15-102(f)(1), *Tennessee Code Annotated*, to reputable building contractors that are principally located within the state and who have demonstrated by past experience their ability to perform construction projects properly;
- procedures used to accumulate the total of state buildings presented in the project accounting system appear proper;
- expenditures charged to building commission contracts are properly classified, documented, approved, and in accordance with state laws, regulations, and contract terms;
- procedures used to dispose of buildings appear proper;
- controls are adequate to ensure complete inventories are maintained in permanent form of all state-owned real property and property leased by the state;
- real property purchases and donations are appraised and valued; and
- real property disposals have proper supporting documentation on file.

We interviewed key personnel about the procedures being used for acquisition, construction, accumulation, and disposal of state buildings and real property and determined if these procedures were in accordance with applicable laws and regulations. We tested a nonstatistical sample of contract payments to determine if the contracts were awarded in accordance with state laws and regulations. We tested a nonstatistical sample of State Building Commission construction expenditures to determine if payments were in compliance with state laws, regulations, and contract terms. We also tested to determine if the payments were properly approved and properly classified in the project accounting system and the State of Tennessee Accounting and Reporting System (STARS). We tested a nonstatistical sample of real property parcels to determine if there were properly completed deeds on file. We tested a nonstatistical

sample of real property purchases and donations to determine if there was adequate appraisal documentation on file. We tested a nonstatistical sample of real property disposals to determine if there was a properly executed quitclaim deed on file and if the property was removed from the land value report timely. In these samples, we also determined if the proper amounts were shown in the state's inventory records for the parcels.

Based on the testwork performed, it appeared that building commission contracts were awarded properly; procedures used to accumulate the total of state buildings and procedures used to dispose of buildings were adequate; and expenditures charged to building commission contracts were properly classified, documented, approved, and in accordance with state laws, regulations, and contract terms. We also determined that controls appeared adequate to ensure complete inventories of real property are maintained, real property purchases and donations were appraised and valued, and real property disposals were supported.

DEVELOPMENTAL CENTER OPERATIONS

The objectives of our procedures at Greene Valley and Clover Bottom Developmental Centers were to determine whether

- adequate controls were in place to ensure that the centers properly administered and accounted for resident trust funds, including patient payroll;
- controls over cash receipts, expenditures, equipment, and inventory at the centers were adequate to ensure that transactions were made in compliance with state rules and regulations; and
- the centers recorded accurate equipment information on the Property of the State of Tennessee System (POST).

We interviewed key personnel about the procedures used and compared these procedures to the applicable laws and regulations. We tested a nonstatistical sample of patient trust fund receipts and withdrawals to determine if they were properly supported and approved. We also tested a nonstatistical sample of resident timesheets to determine if resident payroll was properly credited to patient trust funds. We tested a nonstatistical sample of equipment to determine the accuracy of the information recorded by the centers on POST. For a nonstatistical sample of inventory items, we compared the quantity per the perpetual inventory records to the actual number of items on hand to assess the accuracy of the inventory records. We tested a nonstatistical sample of center expenditures to determine if they were properly approved, properly recorded in the State of Tennessee Accounting and Reporting System (STARS), and handled in accordance with state purchasing rules and regulations. We tested a nonstatistical sample of cash receipts to determine if the amount was deposited properly and recorded correctly.

Testwork revealed that internal control over trust funds and inventories was adequate. In addition, controls over equipment were adequate at Clover Bottom Developmental Center and

equipment was properly recorded in POST. However, several areas of internal control at Greene Valley and Clover Bottom Developmental Centers need improvement. Receipting and procurement duties are not adequately segregated, contracts and disbursements are not properly approved, invoices were not cancelled, bids were not obtained when necessary, and disbursements were not coded to the appropriate object codes. In addition, when examining equipment, we determined that recordkeeping at Greene Valley Developmental Center was inadequate. The center had not performed its annual inventory and did not maintain accurate property records.

44. Internal control at the developmental centers needs improvement

Finding

A review of controls and procedures at the Greene Valley Developmental Center (GVDC) and the Clover Bottom Developmental Center (CBDC) revealed several weaknesses in internal control. At GVDC, receipting duties and procurement duties are not adequately segregated, contracts and disbursements are not properly approved, bids were not obtained when necessary, and disbursements were not coded to the appropriate object codes. At CBDC, receipting duties are not adequately segregated, invoices are not cancelled, bids were not obtained when necessary, and disbursements were not coded to the appropriate object codes.

Duties were not segregated

At GVDC, the accounting technician opens the mail and passes the cash receipts on to the account clerk to write the cash receipt and endorse the checks for deposit only. However, to maintain control over the cash, the individual opening the mail should endorse the checks for deposit only and prepare the cash receipt. In addition, the procurement officer is also the custodian over central supplies. When these duties are not segregated, it creates an environment where the procurement officer could easily purchase and obtain supplies for personal use.

At CBDC, the accountant is responsible for opening the mail and preparing the mail log, cash receipts, and deposit slips. No comparison is made between the mail log, cash receipt book, and the deposit slips by someone independent of those functions. The same accountant is also responsible for performing the bank reconciliations. As such, the accountant has access to the cash, has the ability to write receipts from which posting will occur, has control over the amount of cash deposited, and could cover up any discrepancies through the bank reconciliation. This situation is an invitation for fraud involving large sums of money that could occur and go undetected for a long period of time.

An adequate segregation of duties is a primary component of internal control. Segregation of duties is essential to fraud detection and aids in prevention of possible errors and misappropriation of funds.

Approvals were not obtained for disbursements and contracts at GVDC

According to the *Department of General Services Purchasing Procedures Manual,* Chapter 19.1-6, a voucher register must be signed by individuals authorized by the agency head. At GVDC, this includes the budget officer, the fiscal officer, and the procurement officer. For 11 of 25 disbursement vouchers examined (44%), the voucher was not signed by either the fiscal officer or the budget officer. Approvals from the budget officer and fiscal officer are required to ensure that the center's budget is not overspent and that the requested purchase is necessary for the operation of the center. Also, a contract required for two of the vouchers was not approved by the Department of Finance and Administration until November 2000, although services were rendered in July 2000. Section 12-4-109, *Tennessee Code Annotated,* requires approval of all contracts by the Department of Finance and Administration before any services are rendered. Properly approved contracts are necessary to ensure all parties are aware of the duties and responsibilities of each party and to ensure that agreements are in the best interest of the state.

Disbursements were not handled appropriately

According to the *Department of General Services Purchasing Procedures Manual,* purchases over $400 require three phone bids. At both developmental centers, we obtained lists of invoices that, based on dates and vendors, had characteristics of split invoices. A split invoice occurs when an employee avoids bid requirements on higher dollar items by splitting the invoice up into several smaller invoices. The employee is then able to make a purchase without obtaining three phone bids. Splitting invoices is a method used to circumvent controls and can lead to irresponsible spending. From the listing obtained, we examined 25 of the questionable invoices. At GVDC, 4 of the 25 questionable items (16%) appeared to be split invoices. The invoices were for the same day and the same vendor, and all involved amounts close to $400. At CBDC, 2 of the 25 questionable items (8%) appeared to be split invoices.

Also, at CBDC, invoices were not cancelled. An invoice is usually cancelled by stamping "paid" across the invoice. In a sample of 25 invoices, 7 (28%) were not cancelled. Cancellations ensure that the center does not pay for the goods more than once from the same invoice. In addition, both centers did not use appropriate object codes. At CBDC, 5 of 25 invoices tested (20%) were not coded correctly, and at GVDC, 2 of 25 invoices tested (8%) were not coded correctly. Object codes are essential for proper recording, and the use of incorrect object codes could result in erroneous financial information.

Recommendation

The Fiscal Directors of the developmental centers should improve internal control. The Fiscal Director of GVDC should ensure that cash receipts are written and checks are stamped for deposit only by the same technician who opens the mail. The Fiscal Director should also delegate a procurement officer who is not involved with central supplies. The Fiscal Director of CBDC should immediately designate an employee to perform the bank reconciliation and to compare mail logs, cash receipts, and deposits. This designee should not have receipting or depositing duties. In accordance with the center's policies, a system of control should be

established at GVDC so that each required signature is included on the disbursement voucher before payment and each contract is fully approved before the effective date. The Fiscal Director of each center should review vouchers for characteristics of split invoices and follow up on suspicious transactions. In addition, employees should be trained to assign appropriate object codes and cancel vouchers. These tasks should be occasionally monitored and, when necessary, disciplinary action should be taken.

Management's Comment

Duties were not segregated

We concur. At GVDC, the process has now been changed so that the individual who opens the mail restrictively endorses the checks and logs all cash and checks received. The log is then reconciled to the deposit each day.

At GVDC, the procurement officer is responsible for all of the duties of the procurement office. These duties are separated into distinctive functions for purchasing and receipt/warehousing. There are sufficient controls in the section to insure that two or more people would have to be involved for a shortage to occur and go unnoticed. We feel that the internal control is as economically efficient as possible with the number of personnel available to perform the duties. However, GVDC will review this process to ensure proper segregation of duties.

At CBDC, checks received in the mail will be restrictively endorsed by the Reimbursement Officer and then forwarded to Accounting for the Payroll Clerk to write the receipts and prepare the bank deposit. Someone other than the Payroll Clerk or Reimbursement Officer will take the deposit to the bank. After the deposit has been made, it will be entered into STARS by our Cost Accountant. Bank Reconciliations will be prepared by an Accountant in the Accounting Section.

Approvals were not obtained for disbursements and contracts at GVDC

We concur in part. The disbursement voucher registers were approved/signed by the Fiscal Director or his designee and the Department head or his designee prior to the vouchers being submitted for payment. The division of accounts will not process the voucher register without these signatures. The items listed are utilities, personal services contracts, and residents' allowances which do not require purchase orders to purchase the items and/or services.

While we understand the policy that purchases are not to be made until contracts are approved, in this situation the office of contract review had granted exceptions to the rules to process the contract after the beginning date of service. Had the exceptions not been granted, the contracts would not have been signed. The facility will process all future contracts before the vendor is allowed to start work on a project.

Disbursements were not handled appropriately

We concur in part. At GVDC, while one purchase has circumstances that we feel would not have been a split purchase, the purchases were not reviewed to detect split invoices. The facility will initiate a system that will review vouchers for characteristics of split invoices and follow up on any transactions that are suspicious.

GVDC and CBDC both purchase items for persons residing at those facilities. Occasionally a purchase is made for one of the residents and later in the day a purchase is made for another resident. When the vendor bills the facility, it appears to be a split invoice but, because of timing and the different purchasers and recipients of the goods, the invoice was not intentionally split. This appears to be the case for those items identified for CBDC.

CBDC does use a paid stamp for invoices paid. This stamp is placed on the invoice when the Warrants Report shows the invoice paid. It is their practice to write the date and the Warrant number on the invoice. Due to the volume of invoices processed, a few may be missed. More care will be taken to ensure proper cancellation of paid invoices.

At GVDC and CBDC, due to the number of object codes and the number of people involved in assigning object codes, errors may occur. However, cost accountants review Accounting Reports and correct these errors. In the future when an error is corrected, the invoice or other original document will have any corrections recorded on it. In the case of the Behavioral Analyst services purchased from Team Evaluation for GVDC, though, these services are considered to be non-medical and do not meet the requirements of any specific object code under consulting services and were therefore coded 083999.

Auditor's Comment

Approvals were not obtained for disbursements and contracts at GVDC

Internal control over disbursements was discussed with fiscal staff prior to testwork. We were informed that a disbursement voucher was required for all disbursements and that the vouchers were to be signed by the fiscal officer and the budget officer. The items noted were discussed with the fiscal director in early July. Since that time, GVDC staff have not produced documentation with the fiscal director's signature, nor have they produced a policy excluding these types of transactions from their regular controls. As for contracts, obtaining an exception after work has already commenced on a contract that was not fully executed does not mitigate the finding.

Disbursements were not handled appropriately

Supporting documentation does not usually exist to indicate whether or not valid circumstances created a split invoice. However, through their comments management seem to be acknowledging that at least three of the invoices (GVDC) were indeed split. We also retained documentation that proved that at least one of the invoices was intentionally split.

45. Recordkeeping for equipment at Greene Valley Developmental Center is inadequate

Finding

Greene Valley Developmental Center (GVDC) in Greeneville did not perform its annual property inventory, does not maintain accurate property records, and does not ensure that tag numbers are affixed on each piece of equipment. Also, the duties of the property officer were not consistently performed or reassigned. The property officer was on extended sick leave for the majority of the fiscal year. It is the property officer's responsibility to see that items are recorded on the Property of the State of Tennessee (POST) system correctly. If equipment records are not regularly updated by the property officer, the center will find it increasingly difficult to know what equipment it has and what should be purchased or surplused. The property officer is also responsible for ensuring that each piece of equipment has a state tag attached.

Equipment was verified by selecting 25 items with the highest dollar value. Twenty-five additional sensitive items were also selected for verification. The results of our examination were

- Ten out of 50 property items selected (20%) from the POST property listing could not be located. The cost of the missing equipment was $65,939.78.
- Twelve out of 40 property items selected (30%) were missing the required state tag.

The *Department of General Services POST User Manual* states that each state agency must take an annual physical inventory prior to the close of the fiscal year and requires that uniform procedures be used to transfer, surplus, or delete items from inventory. If the duties of the property officer are not performed and the annual inventory is not conducted, the property records will become increasingly inaccurate. Unauthorized removal of equipment will become increasingly difficult to detect. If tags are not replaced as needed, the center will be unable to match the existing equipment with the financial records on POST.

Recommendation

The fiscal director should ensure that the duties of the property officer are being performed as necessary throughout the year. Corrections to the property list should be made as additions and deletions occur. The property officer should perform the annual inventory to verify the completeness of the list. Property without state tags should be identified, and the tags should be replaced.

Management's Comment

We concur. The person who held the property officer position during the audit period has resigned after finding that his medical problem could not be improved. Due to the uncertainty of

the property officer's situation, which involved continued extensions of sick leave, GVDC did not hire another person into the position. In hindsight, GVDC would have hired another property officer had they known that the sick leave would last as long as it did before the person eventually retired. A new property officer has now been hired. He is receiving training on the POST system. The facility is in the process of taking a complete inventory of all property to insure the proper transition of the property function to the new property officer. Property tags will be added to the property or tag numbers will be permanently engraved/affixed to the items if the property tags will not stay on the items.

FINANCIAL INTEGRITY ACT

Section 9-18-104, *Tennessee Code Annotated*, requires the head of each executive agency to submit a letter acknowledging responsibility for maintaining the internal control system of the agency to the Commissioner of Finance and Administration and the Comptroller of the Treasury by June 30, 1999, and each year thereafter. In addition, the head of each executive agency is also required to conduct an evaluation of the agency's internal accounting and administrative control and submit a report by December 31, 1999, and December 31 of every fourth year thereafter.

Our objectives were to determine whether the department's June 30, 2001, responsibility letter was filed in compliance with Section 9-18-104, *Tennessee Code Annotated*, and to follow up on a prior year audit finding concerning financial integrity act reports that were due on December 31, 1999, not including the Bureau of TennCare.

We reviewed the June 30, 2001, responsibility letter submitted to the Comptroller of the Treasury and to the Department of Finance and Administration to determine adherence to the submission deadline, and we determined that the Financial Integrity Act responsibility letter was submitted on time.

Regarding the prior-year audit finding, we determined that the Bureau of TennCare did not submit the Financial Integrity Act responsibility letter and internal accounting and administrative control report that was due on December 31, 1999 (see finding 46).

46. The Department of Finance and Administration's Financial Integrity Act reports did not include TennCare

Finding

As noted in the prior audit, the Department of Finance and Administration did not include the Bureau of TennCare when filing the Financial Integrity Act responsibility letter and the internal accounting and administrative control report. The only material weakness identified in the responsibility letter and the report was related to the Tennessee Insurance System. Numerous other material weaknesses would have been included if the Bureau of TennCare had been considered. Management concurred with the prior audit finding and stated,

> The Bureau of TennCare has submitted a letter to the Commissioner of Finance and Administration and the Comptroller of the Treasury acknowledging responsibility for maintaining the internal control system. In the letter, we have indicated our intention to complete a Financial Integrity Act evaluation by September 30, 2001. Subsequent to the completion of this review, we will continue to comply with the requirements of the Act.

However, as of December 4, 2001, TennCare has not submitted the required report due every four years.

Section 9-18-102, *Tennessee Code Annotated,* requires that

> Each agency of state government shall establish and maintain internal accounting and administrative controls, which shall provide reasonable assurance that: (1) Obligations and costs are in compliance with applicable law; (2) Funds, property and other assets are safeguarded against waste, loss, unauthorized use or misappropriation; and (3) Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accurate and reliable financial and statistical reports and to maintain accountability over the assets.

Furthermore, Section 9-18-104, *Tennessee Code Annotated,* states,

> (a) By June 30, 1999, and each year thereafter, the head of each executive agency in accordance with the guidelines prescribed under § 9-18-103, shall submit to the commissioner of finance and administration and the comptroller of the treasury a letter acknowledging responsibility for maintaining the internal control system of the agency. (b)(1) By December 31, 1999, and December 31 of every fourth year thereafter, the head of each executive agency shall, on the basis of an evaluation conducted in accordance with guidelines prescribed under § 9-18-103, prepare and transmit to the commissioner of finance and administration and the comptroller of the treasury a report which states that: (A) The agency's systems of internal accounting and administrative control fully comply with the requirements specified in this chapter; or (B) The agency's systems of internal accounting and administrative control do not fully comply with such requirements. (2) In the event that the agency's systems do not fully comply with such requirements, the report shall include and identify any material weaknesses in the agency's systems of internal accounting and administrative control and the plans and schedule for correcting such weaknesses.

The purpose of the Financial Integrity Act is to ensure responsibility for internal control is assumed by top management. By excluding TennCare, the largest program in state government, the Commissioner of Finance and Administration has not publicly acknowledged his responsibility for internal control over the program, nor has he reported a plan and schedule for correcting weaknesses as required by law.

Recommendation

The Commissioner of Finance and Administration should ensure that all areas of the department are included when acknowledging responsibility for controls over such areas. The commissioner should ensure that all material weaknesses are identified and corrective action is taken regarding those weaknesses.

Management's Comment

We concur. The Bureau of TennCare submitted a letter to the Commissioner of Finance and Administration and the Comptroller of the Treasury acknowledging responsibility for maintaining the internal control system. While the evaluation has been performed, the final report is still in progress. The required report will be submitted to the Commissioner and Comptroller by February 28, 2002.

TITLE IX OF THE EDUCATION AMENDMENTS OF 1972

Section 4-4-123, *Tennessee Code Annotated,* requires each state governmental entity subject to the requirements of Title IX of the Education Amendments of 1972 to submit an annual Title IX compliance report and implementation plan to the Department of Audit by June 30, 1999, and each June 30 thereafter. The Department of Finance and Administration filed its compliance report and implementation plan on June 29, 2001. However, this plan did not include the activities of the Bureau of TennCare as noted in finding 47.

Title IX of the Education Amendments of 1972 is a federal law. The act requires all state agencies receiving federal money to develop and implement plans to ensure that no one receiving benefits under a federally funded education program and activity is discriminated against on the basis of gender.

47. The Department of Finance and Administration's Title IX implementation plan did not include TennCare

Finding

The Department of Finance and Administration's Title IX implementation plan did not include the Bureau of TennCare. Section 4-4-123, *Tennessee Code Annotated*, requires each entity of state government subject to Title IX of the federal Education Amendments Act of 1972 to develop an annual Title IX implementation plan.

Section 4-4-123, *Tennessee Code Annotated*, states:

> Each entity of state government that is subject to the amendments of Title IX of the Education Amendments act of 1972, (20 USC 1681 et seq.), and regulations promulgated pursuant thereto, shall develop a Title IX implementation plan with participation by protected beneficiaries as may be required by such law or regulations. To the extent applicable, such plan shall include Title IX implementation plans of any subrecipients of federal funds through the state entity. Each such entity of state government shall submit annual Title IX compliance reports and implementation plan updates to the department of audit by June 30, 1999, and each June 30 thereafter.

20 USC 1681 states:

> (a) No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance, . . .

The Department's plan states that Title IX is "applicable to all of the programs, activities, and operations of the department and the Subrecipient entities with which the department contracts for education activities utilizing federal funds." However, the plan did not include the activities of the Graduate Medical Education program administered by TennCare. The Graduate Medical Education program helps to provide training for residents that agree to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee.

The absence of a Title IX implementation plan, annual compliance reviews, and plan updates could indicate inadequate attention is given to preventing discrimination on the basis of gender.

Recommendation

The Commissioner of Finance and Administration should ensure that the Title IX implementation plan includes all areas of the department receiving federal funds for education programs and activities. The plan should include the Graduate Medical Education program administered by the Bureau of TennCare.

Management's Comment

We concur. Contracts for Graduate Medical Education between TennCare and medical schools prohibit discrimination on the basis of sex. To ensure compliance with Title IX and TCA, the Bureau of TennCare will coordinate activities with Finance and Administration. An implementation plan and subsequent plan updates will be prepared and submitted and annual compliance reviews will be performed and submitted.

OBSERVATIONS AND COMMENTS

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Section 4-21-901, *Tennessee Code Annotated*, requires each state governmental entity subject to the requirements of Title VI of the Civil Rights Act of 1964 to submit an annual Title VI compliance report and implementation plan to the Department of Audit by each June 30. The Department of Finance and Administration filed its compliance report and implementation plan on June 29, 2001.

Title VI of the Civil Rights Act of 1964 is a federal law. The act requires all state agencies receiving federal money to develop and implement plans to ensure that no person shall, on the grounds of race, color, or origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal funds. The Human Rights Commission is the coordinating state agency for the monitoring and enforcement of Title VI. A summary of the dates state agencies filed their annual Title VI compliance reports and implementation plans is presented in the special report *Submission of Title VI Implementation Plans*, issued annually by the Comptroller of the Treasury.

REVIEW OF NURSING HOME TAXES

As noted in the *Tennessee Comprehensive Annual Financial Report* for the year ended June 30, 2001, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), performed a review of the provider taxes collected for the period beginning fiscal year 1992 through September 2000. The purpose of the review was to determine whether there was a correlation between the nursing home provider taxes and a state grant program for private pay patients of nursing homes (Grant Assistance Program). Because CMS believes there is a positive correlation between the nursing home provider taxes and the nursing home grant assistance program, it concluded that the provider taxes are impermissible resulting in a reduction in federal financial participation. On January 19, 2001, the state received a notice of disallowance for this tax for the period October 1, 1992, through September 30, 2000. On February 16, 2001, the state appealed the disallowance. On June 11, 2001, the state received a second notice of disallowance for the period October 1, 2000, through March 31, 2001. On July 6, 2001, the state appealed the second disallowance, and the two disallowances have been consolidated for appeal. If the disallowances, are ultimately upheld, then CMS would offset the disallowed amounts against future federal participation in TennCare. The state eliminated the Grant Assistance Program effective August 1, 2001, and does not believe the collection of provider taxes after that date will be challenged by CMS. The state has reserved $100 million in the General Fund toward any potential settlement or return of the disallowance amounts.

AUDITOR'S COMMENT REGARDING TENNCARE

In January 1994, Tennessee withdrew from the Medicaid Program and implemented an innovative managed care health care reform plan called TennCare. This new plan was implemented within existing revenues and extended health care, not only to Medicaid-eligible Tennesseans, but also to many uninsured or uninsurable persons using a system of managed care. In order to implement TennCare, the state was granted a waiver by the Health Care Financing Administration (HCFA) for a five-year demonstration project. At that time, state rules were promulgated to assist in administering the statewide program of managed health care. The initial demonstration project ended on December 31, 1998. HCFA then approved a waiver extension for three years beginning January 1, 1999, through December 31, 2001. According to discussions with management after fieldwork, there have been two extensions of the waiver. The first extension was for the month of January 2002. The second extension is approved from February 1, 2002, to January 31, 2003.

The Medicaid/TennCare program involves multiple managed care networks, multiple agencies of state government, and most of the state's healthcare providers. The program, therefore, is extremely complex in its operations. Stability of the $5.3 billion program is critical. Due to the sheer size of the program, as well as the numerous federal and state regulations, it is essential that top officials in state government have commitment from all state departments and agencies that play a role in the delivery of health care to the state's Medicaid/TennCare-eligible population.

Federal regulations require the designation of a single state agency to administer the Medicaid/TennCare program. In October 1999, the Bureau of TennCare was transferred from the Department of Health to the Department of Finance and Administration. In November 1999, federal approval was received to designate the Department of Finance and Administration as the single state agency. The single state agency is required to administer or supervise the administration of the state plan for the program. Given this authority, the single state agency must not delegate its authority to exercise administrative discretion in the administration or supervision of the state plan, nor may it delegate authority to issue policies, rules, and regulations on program matters. In addition, the authority of the single state agency must not be impaired if any of its rules, regulations, or decisions are subject to review or approval from other offices of the state.

A recent ruling by a federal court determined that TennCare did not comply with Early, Periodic, Screening, Detection, and Treatment (EPSDT) requirements. This ruling was based upon the court's finding that TennCare violated an agreement from 1998 to provide periodic health screenings to children. This ruling could result in significant changes to the program.

The Bureau of TennCare and state officials are currently in the process of reforming the TennCare program. Although the state has saved money with the managed care system, top officials should continue to seek ways to maintain savings, improve payments to providers, and continue to provide quality health care services to the program's enrollees. Management should continue to strengthen the program from the foundation by focusing on strong internal control

and acquisition of an automated system designed specifically for the managed care environment. As noted in this report, the current TennCare Management Information System does not allow flexibility to efficiently and effectively support the massive Medicaid/TennCare program.

The current audit contains many findings, including repeat findings from several years. Success in some areas of the program will be dependent on the administration's commitment to the single state agency requirement. To make this commitment work, it will be necessary for the administration to require all of the commissioners of the various departments involved in the program to effectively coordinate, cooperate, and comply with the directives of the TennCare Bureau. Such efforts cannot be directed by the TennCare program without the clear support of the office of the Governor.

APPENDIX

DIVISIONS AND ALLOTMENT CODES

Department of Finance and Administration divisions and allotment codes

317.01	Executive Offices
317.02	Division of Budget
317.03	Office for Information Resources
317.04	Insurance Administration
317.05	Division of Accounts – Internal Service Fund
317.06	Criminal Justice Programs
317.07	Resource Development and Support
317.10	Real Property Management
317.11	Commission on National and Community Services
317.30	Management Information Systems
317.86	Tennessee Insurance System
317.97	Telephone Billing
317.99	Division of Accounts - Other
318.60	Office of Health Services
318.65	TennCare Administration
318.66	TennCare Services
318.67	Waivers and Crossover Services
318.68	Long-Term Care Services

339.21 Mental Retardation-Administration
339.22 Developmental Disabilities Services
339.23 Community Mental Retardation Services
339.24 West Tennessee Region (Arlington)
339.25 Middle Tennessee Region (Clover Bottom)
339.26 Greene Valley Developmental Center
355.02 State Building Commission
501.01 Facilities Revolving Fund
501.03 Facilities Management
501.04 Facilities Revolving Fund–Capital Projects
501.05 Facilities Revolving Fund–Debt Service

TENNCARE MATERIAL WEAKNESSES AND QUESTIONED COSTS SUMMARY:

The following table lists all TennCare findings which are classified as material weaknesses or contain questioned costs that are reported in the Single Audit Report for the State of Tennessee for year ended June 30, 2001.

Finding Title / Page No.	Single Audit Finding Number	Finding Type	Federal Known Questioned Costs
Top management must address the TennCare program's numerous and serious administrative and programmatic deficiencies / 22	01-DFA-03	Material Weakness	
The TennCare Management Information System lacks the necessary flexibility and internal control / 132	01-DFA-37	Material Weakness	
Internal control over TennCare eligibility is not adequate / 47	01-DFA-12	Material Weakness	$30,982,562
TennCare did not have adequate due process procedures in place for enrollees, and as a result, the United States District Court issued a Temporary Restraining Order / 34	01-DFA-08	Material Weakness	
TennCare did not require the Department of Human Services to maintain adequate documentation of the information used to determine Medicaid eligibility / 36	01-DFA-09	Material Weakness	
TennCare should seek revisions to the TennCare waiver which would require specific medical conditions for eligibility / 44	01-DFA-11	Material Weakness	
The Department of Finance and Administration did not exercise its responsibility to ensure that the Department of Human Services maintained adequate system security over the ACCENT system / 29	01-DFA-05	Material Weakness	
TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud / 130	01-DFA-36	Material Weakness	
Controls over access to the TennCare Management Information System need improvement / 135	01-DFA-38	Material Weakness	
TennCare incorrectly reimbursed the Department of Children's Services for services that were unallowable or not performed, resulting in federal questioned costs of $803,576 / 59	01-DFA-14	Reportable Condition	$803,576 **

TennCare incorrectly reimbursed the Department of Children's Services over $1.1 million for services that are covered by and should be provided by the behavioral health organizations / 64	01-DFA-15	Reportable Condition	$751,117 **
TennCare should exercise its responsibility to ensure the Department of Children's Services' new payment rates are implemented / 68	01-DFA-16	Material Weakness	
TennCare has not adequately monitored TennCare-related activities at the Department of Children's Services / 69	01-DFA-17	Material Weakness	
TennCare continues to fail to adequately monitor the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded and Developmentally Disabled / 70	01-DFA-18	Material Weakness	
TennCare is still failing to pay claims for services provided to the mentally retarded and developmentally disabled in accordance with the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled / 77	01-DFA-20	Material Weakness	
TennCare has still failed to ensure that adequate processes are in place for approval of the recipient and for the review and payment of services under the Medicaid Home and Community Based Services Waiver / 83	01-DFA-21	Material Weakness	$75,383
TennCare paid capitation payments and fee-for-service payments on behalf of incarcerated enrollees, resulting in federal questioned costs of $4,278,607 / 90	01-DFA-23	Reportable Condition	$4,278,607
TennCare did not recover fee-for-service claims paid to providers and used federal matching funds for capitation payments paid to managed care organizations for deceased individuals including those who had been dead for more than a year / **Error! Bookmark not defined.**	01-DFA-25	Reportable Condition	$7,166 *
TennCare made payments on behalf of full-time state employees, resulting in federal questioned costs of $476,506 and an additional cost to the state of $272,511 / 55	01-DFA-13	Reportable Condition	$476,506
TennCare continues to disregard its own rules regarding overpayments to providers and needs to improve processing of Medicare cross-over claims / 101	01-DFA-28	Reportable Condition	$334 *

TennCare's monitoring of the payments for the pharmacy program needs improvement and TennCare needs to maintain annual drug use review reports / 88	01-DFA-22	Material Weakness	$35,897,909
Against the direction of the Centers for Medicare and Medicaid Services, TennCare inappropriately claimed federal matching funds for premium taxes related to the graduate medical education program and a pool payment made to Meharry Medical College / 98	01-DFA-26	Reportable Condition	$661,464
TennCare made purchases from vendors that did not comply with federal regulations / 105	01-DFA-29	Reportable Condition	$24,445
The Bureau's overall compliance with the special terms and conditions of the TennCare program needs improvement / 115	01-DFA-34	Material Weakness	
Internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations / 121	01-DFA-35	Material Weakness	

For the purpose of this table, a material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements with laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected in a timely period by employees in the normal course of performing their assigned functions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over compliance that, in our judgement, could adversely affect the State of Tennessee's ability to administer a major federal program in accordance with applicable requirements of laws, regulations, contracts, and grants.

Known questioned costs are the actual dollar amounts of transactions discovered through audit testwork that the auditor believes were not spent in accordance with federal laws or regulations. Likely questioned costs are the estimated dollar amounts of transactions that are believed to exist in the population from which samples were drawn that were not spent in accordance with federal laws or regulations.

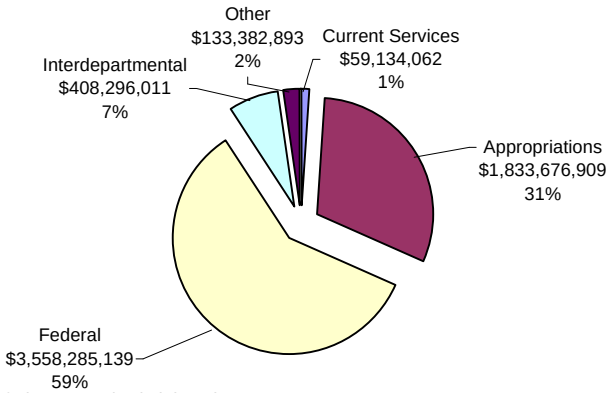
* We believe likely federal questioned costs associated with this condition exceed $10,000. We are required by the *Office of Management and Budget Circular A-133* to report all situations where known or likely questioned costs for a major federal program exceed $10,000 for a type of compliance requirement.

** A review of our CAATs associated with the issues noted in these findings revealed that our results sometimes included duplicate questioned costs. For example, costs for an incarcerated youth that was also receiving alcohol and drug treatment would be questioned twice, once in the

test of incarcerated youth and once in the test of youth receiving alcohol and drug treatment. We estimate the federal share of duplicate questioned costs which are included in the questioned costs mentioned in the schedule above to be approximately $197,532. See findings 15 and 16 for further details regarding these matters.

Departmental Funding Sources

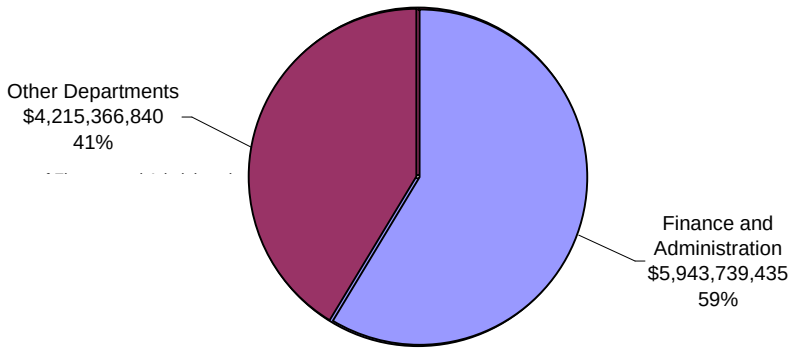
Fiscal Year Ended June 30, 2001 (Unaudited)



Source: Department of Finance and Administration
Note: OIR, Tennessee Insurance System, Division of Accounts, Facilities Revolving Fund, and State Building Commission are not included because they are not part of the General Fund.

General Fund Departmental Expenditures

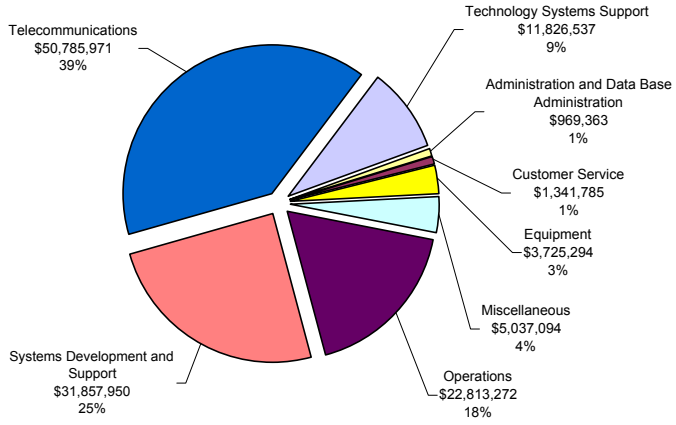
Fiscal Year Ended June 30, 2001 (Unaudited)



Source: Department of Finance and Administration
Note: OIR, Tennessee Insurance System, Division of Accounts, Facilities Revolving Fund, and State Building Commission are not included because they are not part of the General Fund.

OIR Total Billable Services - $128,357,266

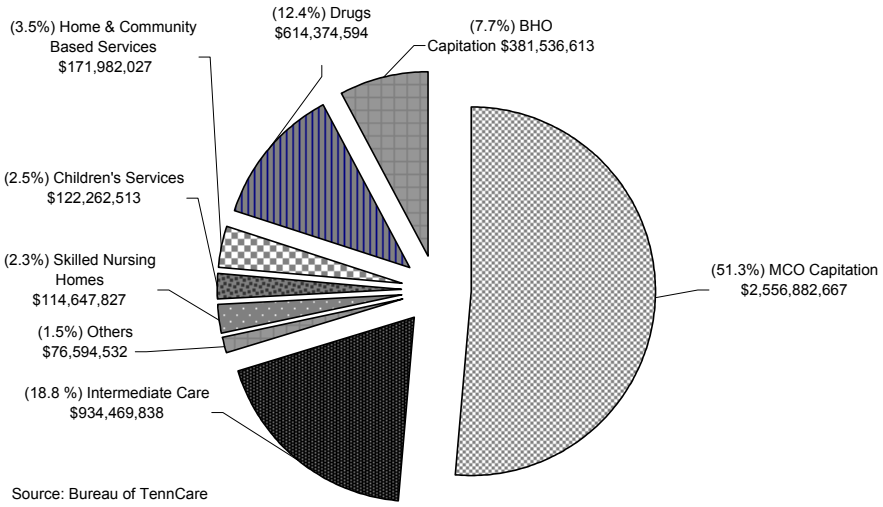
For the Year Ended June 30, 2001
(Unaudited)



Source: Department of Finance and Administration

TennCare Dollars Paid by Claim Type

Fiscal Year Ended June 30, 2001 (Unaudited)



Source: Bureau of TennCare